		3.2	per FH 03-29-		rimcale 0	Death		F	leg. No	0 1	1100
D		1. Decedent's Name (First, Middle, Last))				2.	Date of Dea Month	Day	Year	3. Time of Death
Physic /Medi		William D	owney Henle	y, Sr.			M	larch	21, 200	77	5:30 A N
Exami		4a. Facility Name (If not institution, give	street and number)			n, or Location of	f Death		4c. County		
	М	12 Park Avenue			Mount If Under 1 Yes		24 Hrs. D	Date of Blat	Carro		
Funeral Director		5. Social Security Number 6. Security S	x 7. Age (in yrs	s. last birthday, Yrs.	Months Day		Min. J	Date of Birth Month, Day June 2	, Year 1918		place (State or Forei ntry yland
A II		10a. State 10b. County	10c. C	City, Town or L	ocation					1	Od. Inside City Limi
등급	ţ	Maryland Carroll	-	Mount A	Airy						Yes 2□N
28	Director	10e. Street and Number			10f. Zip Code	е			10g. Citizen of	What Cour	ntry?
23a	alD	12 Park Avenue				21771			U	.S.A.	
ilene. r than "natural", or Items 23s or 28s-1 show the Medical Examinat intellibed at	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give		Was Decedent of If Yes, specify C		gin? (Specif , Puerto Ric	ty Yes or No- can, etc.)	14. Rad Bla Specif	ck, White,	
Ex	d by	3 Widowed 4 Divorced	Year or Dates: WW					-		WILT	
Tage and the same of the same	lete	15. Decedent's Edu (Specify only highest grad		(Give	edent's Usual Oct e kind of work do DO NOT use ret	ne durina most	of working		16b. Kind of B		_{dustry} Appliance
Il Hygiene. other than vent, the M	Completed	Elementary/Secondary (0-12) I 2 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		er/Opera	tor	r'a Nama /i	Circt Middle		Cente	
ag d ≥	To Be	Oliver Granvill	e Henley				annie			Young	5
and e m	1	19a. Informant's Name/Relationship (7) Martha M. Henley	, Wife		ing Address (Stre						
Heeith tem 27		Martha M. Henldy	- Wife	er of annual con-	Park Ave	100	lount Dat		Maryla		21771
0 .		20a. Method of Disposition 1 Aburial 2 Cremation 3 F 4 Denation 5 Other (Specify)	Removal from State	cemetery, cre	osition (Name of matory or other p cove Cem	place)	03/24		Mount	•	Maryland
Depertment of Important: If any Injury or 20058.		21. Signature of Funeral Service Lisens	Villus	m/ Mc	2.Name and Adoleswort 5401 Rid	dress of Facility h-Willi ge Road	lams F 1. Dan	P.A., I	Funeral Marvl	Home and	20872
Medical			2	INE	CARDI	ongop	19149	7		In	
		resulting in death) Sequentially fist conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	equence of):	CHROI	ongop	MIHT	,		m	Onset and Death UNTHS — GFa
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07-02569 Austin M. Jenkins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ustin M. Jenki	stin M. Jenkins Amend #8State of Mardand Apenatynent of Health and Mental Hygiene 1-For State Reg. No. Reg. No.									7 1150		
Physici Medical Exam	ian/	Decedent's Name (First, Middle, Last)	-		_		2. Date of Month	Day	Year	3. Time of Death 1345 hrs		
neulcar Exam	mer	Austin Mitchell Jenkins 4a. Facility Name (if not institution, give street and number))		4b. City, Town, or I	Location of E	April 4		tc. County of Dea			
		Frederick Memorial Hospital			Frederick				Frederick			
Funeral		5. Social Security Number 6. Sex 7. Ag	ge (in yrs. la	ast birthday)	If Under 1 Year Months Days		Min	20	M2 Fore	Birthplace (State or eign		
Director		218-63-7824 1XM 2 F	4	Yrs.			05/1	8/2 0	07	Country)Maryland		
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locati	on					10d. Inside City Limits		
vlaryland 28a-f show any <u>1 at once.</u>	ا ا	Maryland Frederick						1 X Yes 2 No				
Maryla 28a-f d at o	rector	10e. Street and Number		10g. C	itizen of What Co	ountry?						
eath with the Maryland items 23a or 28a-f sho ust be notified at once	ij	105 Deerfield Place		a. Traini	21702		2 / O / V	USA				
ath wi	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces'	?		s Decedent of His es, specify Cuban				White, etc.			
fter de I", or		3 Widowed 4 Divorced If Yes, Give Year or Dates:	X No	1	Yes 2X No	specify:			Specify: Wh	ite		
nours a	ed by	15. Decedent's Education (Specify only highest grade cor			t's Usual Occupati ost of working life.			16b	. Kind of Busines	s/Industry		
136 hin 72 hou e. than "nat	plet	Elementary/Secondary (0-12) College (1-4 or	5+)	N/A				l N	/A			
15-003 iled withi Hygiene. d other ti	Completed	17. Father's Name (First, Middle, Last)		N/A		18.Mother's I	Name (First, Mide		•			
21215-0036 uld be filed within 72 hours after Mental Hygiene. nnarked other than "natural", e event, the Medical Examiner.	Be	Aaron Michael Jenkins, Sr.				Tosha	Marie V	lills				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is unarked other than "natural", or items 23a or 28a-f shu raife event, the Medical Examiner must be notified at once	입	19a. Informant's Name/Relationship (Type, Print)			Address (Stree							
and 2 she tealth and trem 27 is		Tosha Marie Wills, mother 20a Method of Disposition		Place of Dispos	Deerfield lition (Name of cer		Date	200	Location - City	and 21702 or Town, State		
Baltimore, MD 21215-00 pemir. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other frammatic event, the Mark		1 Burial 2 X Cremation 3 Removal from St 4 Donation 5 Other Specify:	late	rematory or oth		ory	4/10/200	7 51	mithshur	o Maryland		
altir mit. F partme ipnrta		21. Signature of Funeral Service Ocensee	_ Din	22. N	lame and Address	of Facility	Keeney a	ınd B	asford l	g, <u>Maryland</u> Funeral Home		
	\vdash	23a. Par I. Enter the disease, or complications that caused	Fre	derick.								
Physician		failure. List only one cause on each line.	a ine deain	, Do not enter ti	ne mode or dying,	suci as care	alac or respirator	y arrest, s	Hock, of Hourt	Between Onset and Death		
Examine		Immedi #e Lause (Final disease or condition resulting in death) a. Drownin: Due to (or as a consequence of):										
•	_	Sequentially list conditions, b										
	nine	if any, leading to immediate Due to (or as a conscause. Enter Underlying Cause (Disease or injury that initiated	sequence o):								
Is a fu	Examiner	events resulting in death) Last Due to (or as a cons	sequence o	of):								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the build i transit	ledical	X UNPENDED 4MENDED 7,28	20f #	orME CO	67 5/10/07	TTT						
'60, ate be ohysici	Med	#2.31,27,20. IF FEMALE: 23c. If yes, outcome and the second seco			07,3/10/07	, 11		12	23d. Date of deliv	•		
Ox 6876 eath certificate attending phy for use as the b	ian/	23b. Was decedent pregnant in the past 12 months?	at time of de		ther (Specify)	Ectopic p	regnancy		Month	Day Year		
Box e death the atter	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown		5 [] OI	ther (Specify)				<u></u>			
that the d	by P	Part II. Other significant conditions contributing to dea	th but not r	resulting in the t	underlying cause of	given in Part	I. 23e. I			to the cause of death? Probably 4 Unknown		
ords, P.C. w requires that is been signed I should be deta	_							Was an		autopsy findings available		
COFC law recharbes be	Completed					-	_	autopsy performed	? death			
tal Recian: The		25. Was case referred to medical			26.Place	of Death (C	heck only one)	Yes 2	No 1 🗸	Yes 2 No		
Vital ysiciar his cen	o Be	evaminer?	ient 2 🗸	ER/Outpatien	t 3 DOA	Other 4	Nursing Home	Res	idence 6 O	ther:		
Ing Ph After t	-	27. Manner of Death 28a. Date of In (Month, Day)	jury ,Year)	28b. Time of		ry at Work?			injury occurred			
Sion Attend death. ctor:	atio	Natural 5 Pending Fnd 4/4/ 2 X Accident Investigation		Fnd 12:	35 pm 1 et, factory, office t	Yes 2X N	,			Rural Route Number, City		
Division pital or Attentours after deatheral Director:	Certification:	Suicide 6 Could not be determined (Specify)		in batht		odiidiiig, etc.	or To	wn, State	ld Pl. Fre	ederick, MD		
Hospit 24 hour Funer rely fill		29a. Certifier 1 Certifying Physician: To the best of r	my knowled	dge, death occu	rred at the time, d	ate and plac	e, and due to the	cause(s)	and manner as	stated.		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of example and manner stated		and/or investiga			urred at the time,					
- 3 - 3	Ž	29b. Signature and title of certifier	1		29c. Licens	se number M.E.			d. Date signed (pril 5, 2007	'Month, Day, Year)		
	1				0.0.			1′`	F 0, 2001			
		20 Name and adding 1	dooth /tre-	m 23a\								
V.		30. Name and address of person who completed cause of Susan Hogan MD. Assistant Medical E			nn Street, Bal	timore, M	D 21201					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1 Decedent's Nama (First Middle | ast) Month Day Yea 055 Physician ones 2007 /Medical 4b. City, Town, or Location of Daath 4c. County of Daath 4a Facility Neme (If not institution, giva straat and numbar) Examiner UNIVERSITY SPECIALTY HUSPITAL BALTIMURG If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 06-18-1950 9. Birthplace (Stata or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax Days **Funeral** Months 100 M 2□ F 56 220-52-8824 Director Usual Rasidenca of Dacedent 10c. City, Town or Location 10d. Insida City Limits 10a Stata 10b. County f Health end Mental Hygiene. tem 27 is marked other than "naturel", or items 23s or 28e-f show other traumstic event, the Medical Examiner must be nothed at 1 Yes 2 □ No Director Maryland Dorchester Hurlock 10g. Citizen of What Country? 10f. Zip Coda 10e. Street and Number 21643 IISA 119 Douglas Drive Funerai 12. Was Dacadant Evar in U,S. Armed Forcas? 1 X Yas 2 □ No If Yes, Giva 13. Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after on the file of Health end Mental Hygiene. 1 Navar Married 2 Married 1 Yes 20 No Specify: Spacify: 3altimore, Maryland 21215-0020 ۵ **Black** 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Dacedant's Education (Spacify only highast grada complated) Self Employed Collega (1-4or 5+) Elemantary/Sacondary (0-12) Barber Barber 18. Mother's Name (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Ruth Cartwright ဥ Leon Jones Herbert 19b. Mailing Address (Straat and Numbar or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) Depertment of Health important: If Item 27 I 119 Dougles Drive, Hurlock, Maryland 21643 Bernet Jones / Wife 20c Location - City or Town, Stata 20b. Placa of Disposition (Nama of cemetery, cramatory or other place) 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. 03-26/07 Hurlock, Maryland 21. Signatura of Funeral Sarvice Licensas 22. Nama and Addrass of Facility
Bennie Smith Funeral Home 516 S. Main Street, Hurlock, Maryland 21643 amnie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaen Onsat and Daath Physician Immediata Cause (Final disaasa or condition resulting in death) Maintig at · Cerebro Vascular Examiner Examiner physician and the buriel-trensit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiate causa. Enter Undarlying Cause (Disaasa or injury that initiated avants rasulting in death) Last Box 68760. per tenson Physician/Medical Dua to (or as a consaquenca of): attending ph 23b. Did tobacco usa contributa to the causa of death? Part II. Other algnificant conditiona contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformad? Completed page 2 s After this certificete has 1 Yes 2 No 1 ☐ Yes 2 ☐ No ours after death.

oral Director: After this certifice filled in by the funerel director, I Hospital or Attending Physician: 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Be Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Hospital: 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA ို 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yaar) 28b. Time of 27. Menner of Death Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not ba 28a. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Streat and Numbar or Rural Routa Number, City or Town, State) 3 Suicida 4 Homicide 24 hours Lactifying Phyaician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and manner es stated.

2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and mannar steted. Medicai 29a. Certifier within 24 hour To the Fune completely file (Check only one) To the 29d. Date signed (Month, Day, Year)

March, 20, 2007 29b. Signature and title of certifier 29c. License number Aprolite 29 034974 2-1V 30. Name and address of person who complated cause of death (Itam 23a) (Typa, Print)
CHARU MEHTA, MD, 60/SOUTH Charles Street Baltimore, MD21230

State Registrar

MAR 2 2 2007

31. Data filad (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #5 Per Inf G866 4/27/07 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** 34 pm Helen Elizabeth Jones arch 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Sept. 7, Birthplace (State or Foreign
Country) Year) 1944 **Funeral** Days Hours 1 □ M 2 🙀 F Washington, DC Sept. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show ns 23a or 28a-f show must be notified at 1 No 2 No Director Maryland | Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13138 Ripon Place 20772 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 Is marked other than "
of traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Lead Nursing Assistant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Jones Marjorie Young ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if Health a it of Health If Item 27 or other t Maria Barkley/Daughter 3228 Sycamore Lane, Suitland, Maryland 20746 Date 2007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ★Burial 2 Cremation 3 Removal from State Department o Important: If any injury or 4 □ Donation 5 □ Other (Specify) Harmony Memorial March28, Landover, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Sign of Funeral Service Licence 5538 Marlboro Pike, Forestville, Maryland 20747 M0105 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Leiomyosarcoma **Physician** 3 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter this being Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29c. License number 29d. Date signed (Month, Day, Year) D41715 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6201 Greenbelt Road,

State Registrar Chitra Venkatraman, MD 32. Registrar's Signature

31. Date filed (Month, Day, Yea MAR 28 2007 College Park, Maryland 20740

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JOHNSON JR. RUFUS 2001 arci /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE"S LANHAM DOCTORS HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Days Hours Min. 1 M 2 □ F 55 227-72-9260 1951 VIRGINIA DEC. 17 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 TYes 2 □ No OXONHILL PRINCE GEORGE'S Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20745 809 IRVINGTON STREET # 302 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☑ Married BLACK 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4or 5+) PARKING MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EVA CHRISTINE HALL RUFUS JOHNSON SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) IRVINGTON STREET #302 OXONHILL, MARYLAND 20745 PATRICIA A. JOHNSON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: if it any injury or o once. Department of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State JERUSALEM CEMETERY 3/31/2007 | JARRETT, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) d **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of): Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2∑No 24a. Was an autopsy performed? 1∐ Yes 2 No page 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 Homicide To the Hospital of vithin 24 hours all to the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1 9 0 mostigues MDD 179 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATA-0 MOSHYEDI M.D. 7305 Hanover Parkway GreenBelt MD 20

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
MAR 2 8 2007

To the Hospital State Registrar

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

death with the Maryland

Baltimore, Maryland

Pages 1

permit.

31. Date filed (Month, Day, Year) 28 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

MAD 60611

P 3118 6000 LUCK ROAD LANHANMO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL 07 2007 0556 **Kelley** Elizabeth 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) WMHS--Memorial Campus CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) Aug 7, 1927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Days Hours Min. 1 M 2 K 216-22-5890 MD 79 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No MD Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 9 N. Waverly Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ **X**o white 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Joseph Coyle Adrianne Mary (Will) Coyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Randall Kelley 9 N. Waverly Terrace Cumberland MD 21502 son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 4/8/2007 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 23d. Date of delivery Month Year use contribute to the cause of death? □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 6 ☐Other (Specify) ry occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director be notified

Funeral

by

Completed

Be

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

ther than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 1

Baltimore, Maryland 21215-0036

burial-trar the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifical funeral

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

filled in by To the Hospital of within 24 hours af To the Funeral C completely filled i

Examiner	Sif OC th
Certification: To Be Completed by Physician/Medical Examiner	IF 2:
y Ph	P
P P	_
Complete	_
Be	2
2	
Sertification:	2

Sequentially list conditions, if any, leading to immediate dauge. Enter University Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ⊎πκποwn	c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3□Ectopic	pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions cont	ributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death 2 □ No 3 □ Probably 4 ☑ Unkr
				24a. Was an autopsy performed 1 Yes 2 ☑	
25. Was case referred to medical examiner?	agnital:		1 Othor:	Death (Check only one)	
1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other 4 Nursing	g Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fac fy)	tory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number late)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) , 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vikramaditya 31. Date filed (Month, Day, Year) APR 1 1 2007

Registrar's Signature

and manner stated

Cumberland, MD. 21502

State

Registrar

Seton Drive

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No:-3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 10:35 AM **Physician** RHOADES KEER JOANNE APRIL 2007 -LIZABETH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** FEY QUEEN CHESTERTONN 537 RUAD ANNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔭 F 89 283-16-5958 Yrs. DEC 27 1917 MAIN Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. fnside City Limits 10b. County or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other trsumatic avent. Ins Mudical Exactinar must be notified at 1 Yes 2 No CHESTERTOWN MD QUEEN ANNES Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 454 21620 ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Efementary/Secondary (0-12) Colfege, (1-4or 5+) ARTIST 1.2 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RHOADES BOUFFORD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21620 19a. Informant's Name/Relationship (Type, Print) CHARLES 203 EAST CAMPES ANNE AVE. CHESTERTOWN, MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 4/4/07 CHESTER, MO HESAPEAKE CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ans. TR FUNELL DIRECTUR any. Parvin V CHESTERTOWN, MD (205 GREEN HEREN LUMY) ZIEW 23a Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau pon each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) totic adeno arcomo letes **Physician** /Medical Due to (or as a consequence of) Examiner S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Tunknown been signed by 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has certificate 1 ☐ Yes 2 No or Attending Physicien: completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? : After t 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number of Rural Route Number, City or Town, State) 4 Momicide within 24 hours a To the Funerei C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20060301 npleted se of death (Item 23a) (Type, Pript) Ren Pa) SRS CORS I more ms 31. Date filed (Month, Day, Year) APR 0 32. Registrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	ıryland		artment o				giene g Reg. No.	2007	11509	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MARY LOU MILDRED	KNIGHT						2. Date of De Month MARCH	29, Day	.007 ^{Year}	3. Time of Death 18:17 P M	
	Examin		4a. Facility Name (If not institution, give s CHESTER RIVER HOS		TER		СН	ESTE	cation of Death	1	4c. County of Death KENT			
	Funeral Director		000-32-1932	м 21XF 7. Age	(In yrs. las	st birthday) Yrs.	Months D		f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11/23/	1940	9. Birthp Cour	place (State or Foreign htry) NY	
	Maryland -I show	tor	Usual Residence of Decedent 10a. State 10b. County MD KENT			Town or Lo						1	0d. Inside City Limits 1 Yes 2 □ No	
	3a or 28a	i Director	10e. Street and Number 207 MAIN STREET,	APT 1N			10f. Zip Co	610			_	on of Whal Coul	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, I'ra Medical Examinar must be notified at once.	by Funerai	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	I2. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi			Mexican, Puert	pecify Yes or No o Rican, etc.)		I. Race - Americ Black, White, Specify: WF		
21215-0036	within 72 ho ene. than "natur re Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		+)	(Give life.	DO NOT use r	done dui retired)	on ring most of wor	rking		of Business/In	dustry	
and 2	ild be filed lental Hygi ked other Ic avant, I	HAIRDRESSER 17. Father's Name (First, Middle, Last) EDWARD AMBROSE 18. Mother's Name (First, Middle, Last) MILDRED FRAWL								iumame)				
Maryland	nd 2 shou alth and M 27 is mar ir traumat		EDWARD AMBROSE #ILDRED FRAWLEY 19a. Informant's Name/Relationship (Type, Print) JOHN KNIGHT SR./HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St 207 MAIN STREET, APT 1N, BETTERTON,											
Baltimore,	Pages 1 a nent of Hea ant: If Itam ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Cer	metery, crei	sition (Name matory or othe KE CRE	ir place)	ON 03/	Date 31/2007		ation - City or T		
21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FU 130 SPEER ROAD, CHESTERTOWN, MD 2										FUNERAI 21620	L HOME, PA			
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. OR ON ARY ARY DISEASL Due to (or as a consequence of): Due to (or as a consequence of):											
8760,	physician and purial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as		ence of):	o r E v	14	Rel	Emi	A			
.O. Box 68	death certifi e attending od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, oulcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	∃Ectopic preg ∃ Other (spec				23	3d. Date of deliv	rery Day Year	
σ	iw requires that the s been signed by th should be detache	þ	Part II. Other significant conditions con	ntributing to death b	ul nol resul	Iting in the u	inderlying cau	se given	in Part I.		tobacco us		the cause of death?	
of Vital Records	The la	Completed	,								s an opsy ormed? 2 D No	24b. Were aut prior to codeath?	opsy findings available ompletion of cause of 2 No	
Vita	ysiclan: is certific director,	To Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatie	ent 2 🗆 8	R/Outpatie	nt 3 DOA	Other		ath <i>(Check only</i> Home 5 ☐ Res		☐Other (Spec	ify)	
ion oi	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di		27. Mannyl of Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury	of 280	: Injury a Work? 1 🗆 Ye	at es 2 □No	28d. Describe	how injury	occurred		
27. Mann of Death 1							reet, factory, o	office			(Street and own, State)	Number or Rui	ral Route Number,	
	na Hospital n 24 hours a na Funeral I	edical	29a. Certifier 1 Cartifying Phy (Check only one) 2 Madical Exami	sician: To the best ner: On the basis o and manner sla	f examinati	vledge, dea ion and/or ir	th occurred at ovestigation, in	the time n my opi	e, date and place nion, death occ	e, and due to the urred at the time	cause(s) a	and manner as place, and due	stated. to the cause(s)	
	To tha within 2 To tha complet	Me	29b Signature and title of certifier	100	\ N	\sim	29c. 1	License	405	4	29d. Date	signed (Month	Day, Year)	
			30 Name and address of person who con Patrick J. Stran	ahant	SI O	30S	Print) DOCK	RD.	BlogR	S Ches	terte	Mas	Dallac	
ž	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 3 0	2007 32. Records	ar's Signat	ure	book	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year **Physician** Apr 6, 2007 0810 M Lewis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Co. Rehab. & Nursing Ctr. Allegany Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb 16, 1922 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex MD 1 ☐ M 2 ☑ F 217-18-4809 85 **Director** Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h Counts 1,□Yes 2□No Cumberland MD Allegany Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 227 Offutt Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 1 □ Never Married 2 □ Married 1 Yes Z No Specify: Specify: white **X**□Widowed 4 □Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Laborer Celanese 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edith Kenney Lease Frederick Lease 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 233 East Offutt Street MD 21502 Cumberland Andrew Lewis son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/10/2007 Sunset Memorial Park MD Cumberland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature Funegal/Service Lice 108 Virginia Avenue: Cumberland, MD 21502 a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KIDNEY MOS Physician END STAGE /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2€ No 1 TYes 2 No 26. Place of Death Check onl one 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔂 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, s been signed by t should be detach page 2 s certificate this After

Funeral

ir than "natural", or Items 23e or 28e-f show the Medical Examinar must be rediffed at

Pages 1 and 2 should be filed v tment of Heath and Mental Hygie tant: If item 27 is marked other t jury or other traumetic event, In

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: A filled in by

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

cal

DR ROBUSTIANO J. BARRERA

APR 1 1 2007

17-14-865

TEL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Le Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEMORIAL MED RLDG. CUMB, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature

10

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** \mathbf{p}^{M} Lukas Laskaris March 22, 2007 4:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1X M 2 □ F Yrs Director 67 230-76-0512 December 14,1939 Greece Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notifled at Director 1 ☐ Yes 2 No Mary land Montgomery Rockville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4408 Hallet Street 20853 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 2 Parts Manager Automotive other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Avgerini Coukos Ioannis Laskaris ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any Injury or other trai once. Heidi Laskaris - Wife 4408 Hallet Street, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 3/27/2007 Brentwood, Maryland Fort Lincoln Crematory 21, Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. Approximate Interval Between Onset and Death immediate Cause (Final Physician disease or condition resulting in death) Multiple Organ Failure /Medical Due to (or as a consequence of) Examiner Fever/Septic Shock 3-4 days Sequentially list conditions, if any, leading to immediate cause. Enter Unuenying Cause (Disease or injury that initiated appart Due to (or as a consequence of) The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Po in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No P.O. signed by the a d be detached t 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Renal Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Respiratory Failure/Hypoxia 24a. Was an has e 2 certificate has rector, page 2 autonsy perform 2 🕱 No 1∐ Yes Diabetes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 4 No မ 1 Nation 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 24 hours 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 To the F To the F 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) March 22, 2007 D64174 30. Name and ad of person who completed cause of death (Item 23a) (Type, Print) Vikas Jogi, M.D., 1500 Forest Glen Road, Eilver Spring, Maryland 20910 31. Date filed (Month, Day, Year) Registrar's Signature State **順点尺 28** Registrar

			1 _ State		artment of Health and	d Mental H		0007	11510	
			Registrar 1. Decedent's Name (First, Middle, Last)		Timodio of Bodin	2. Date of	Reg. No.		3. Time of Death	
E	Physici		Betty Jane Lambo	ert		Month	n 28,	Year	11:44P M	
	/Medic		4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location of Di			4c. County of Death		
E	Examir	ier	28520 Kemptown Road	,	Damascus			Montgomery		
	Funeral		5. Social Security Number 6. Sex 7	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 I	Hrs. 8. Date of	Birth Day, Year)		place (State or Foreign intry)	
	Director		215-26-3424 1□ M 2ŪXF	76 Yrs.	Months Days Hours N		25 , 1		ryland	
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	anyla ehov	2		10c. City, Town or Lo					10d. Inside City Limits	
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	with t	ā	28520 Kemptown Road		10f. Zip Code 20872			izen of What Cou S.A.	mu y ?	
	within 72 hours after death with the Maryland ane. Then "netural", or feme 23a or 28e-f ehow ha Madical Examinar must be notified at	Funerai		dent Ever in U.S. 13.		(Specify Yes or		14. Race - Amer	ican Indian.	
^	e e e	퓌	Armed Ford 1 □ Never Married 2 □ Married 1 □ Yes	2 (X) No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.)		Black, White	, etc.	
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N	ed wi	ပ္ပ		Ho	omemaker)wn Home		
yland	iai dott dott	Be	17. Father's Name (First, Middle, Last)			Name (First, Mid		Sumame)		
<u> </u>	Men Men Marke Marke Men Men Men Men Men Men Men Men Men Me	၉	Raymond James Herberson			ta Mae l				
<u>8</u>	12 st h and 7 le n traun		19a. Informant's Name/Relationship (Type, Print) John Richard DeBow, Sr.		ing Address (Street and Number of					
ტ ე	1 and Healt Healt ther		20a. Method of Disposition		Guilford Road,	Date	-	mary Lame ocation - City or T		
ē	ages nt of t: If it		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from S	olate	osition (Name of matory or other place)	/31/07				
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural; or Iteme 23a or 28e-f show any injury or other traumatic event, the Madical Examinar must be notified at Anne.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		1. Cemetery 3 2. Name and Address of Facility	/31/0/	Fre	derick,	Maryland	
n	Depe Impo any lo		Months Jum (W)	ORR	Molesworth-Wil 26401 Ridge Ro	liams P	A., F	uneral	Home	
			23a. Part1. Enter the disease, or complications that ca	used the death. Do not en				магута	Approximate	
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X P Q	death of etten	ian	in the past 12 months?	nth 2 ☐ Fetal death 3 ☐	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of delik Month	ory Day Year	
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္ဌ	s bee	Siete	RENAL FAILUR	2 E		24a. W	as an	24b. Were aut	opsy findings available	
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>	nysic lis ce direc	To B	examiner? 1 ☐ Yes 2X No Hospital: 1 ☐ In	npatient 2 ER/Outpatier	Othor			6 ☐ Other (Speci	fy)	
Ö	ng Pr fter th		27. Manner of Death 28a. Date of 1X Natural 5 ☐ Pending (Month	f Injury 28b. Time o		28d. Descri				
Nision	eath. or: A the fu	cati	2 Accident investigation		M 1 Yes 2 No					
<u> </u>	or At fler d Direct in by	ertification;	determined 200. Place (of Injury - At home, farm, str ig, etc. <i>(Specify)</i>	reet, factory, office		n (Street an Town, State		al Route Number,	
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical	29a. Certifier (Check only one) 2 Medical Examiner: On the base and manner	sis of examination and/or in	in occurred at the time, date and pl evestigation, in my opinion, death o	ace, and due to t ccurred at the tin	ne cause(s) ne, date and	and manner as: place, and due	o the cause(s)	
	omple omple	Me	29b. Signature and title of certifier	or otatou.	29c. License number		29d. Dat	te signed (Month	Day, Year)	
	->-0		+ July my	ale de	D23630		Mar	ch 29.	2007	
4	6		30. Name and address of person who completed cause							
,	(7)		Frank J. Mayo, M.D. 162	220 Frederick	Road, Suite 21:	3. Gaith	ersbu	rg, Marv	land 20877	
	Sta		31. Date filed (Month, Day, Year) MAR 2 9 2007	gistrar's Signature	/ w.					
	Registr	rar	MAR & 9 2007	due st f	DENCY					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^D2007 March 23, **Physician** 2:50 p. M Charles P. La Marca "/Medical 4h. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick 909 East A Street Brunswick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 **X** M 2 □ F September 30, 1914 054-07-8805 New York 92 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he provided once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ¥Yes 2 No Directo Maryland Brunswick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 909 East A Street 21716 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2X No Specify: Specify. þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lighting Shop Foreman 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unk) Maria Cosmo La Marca ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 909 East A Street, Brunswick, Maryland 21716 Ann Cook - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/28/2007 Frederick, Maryland Stauffer Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL **Physician** I Mo. /Medical Due to (or as a consequence of) 2 40. **Examiner** UROPATITY 18STRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 6 MO g physician and as the burial-transit CARCINOMA BLADDER Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by STENOSIS 1 Tes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 nours after death.

neral Director: A death. within 24 hours a

To the Funeral C

completely filled i

altimore, Maryland 21215-0036

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29d. Date signed (Month, Day, Year)

MAR. 27,

2007

D10587 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A (DI CIL DI ILECTOL HOSPICE OF FREDERICK CO. GEORGE 516

DIRECTOR

MEDICAL

State Registrar

Medical

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 04 05 2007 1710 MCKENZIE JAMES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jun 27, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 215-20-5128 1925 MD 81 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1□Yes 2□No MDAllegany Cresaptown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P.O. Box 5535 21505 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★ Yes 2 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner 1 ☐ Never Married Ž☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 □ Yes 2 No 2 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Smith Engineering labo<u>rer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emory M. McKenzie Elizabeth (McBee) McKenzie ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 5535 MD 21505 Lorraine McKenzie wife Cresaptown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 4/9/2007 MD Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service License, 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DN6CTTVE **Physician** YCARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DILONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 by Physician/Medical the as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 21 HO 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1000 To the Hospital or Attending Physician: 25. Was case referred to predical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2010 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA P nours after death. neral Director: After this villed in by the funeral di 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I completely filled 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 0,50844 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certi

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10

State Registrar 30. Name and address of person

31. Date filed (Month, Da

912 FOTON DRIVE CUMBERLAND, MD2 1502

oleted cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MINNIE MILLER 04 0140 05 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Jun 10, Birthplace (State or Foreign Country) D 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2√F Months 1915 Director 91 212-38-6320 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Oldtown MD Allegany 1 ☐ Yes ♀☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21555 USA 18319 Oldtown Road, SE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1□Yes 2□Xo Baltimore, Maryland 21215-0036 Specify: white þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oldtown School cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be file int of Health and Mental H: If Item 27 Is marked oth Be Charles P. Adams Bertha Twigg Adams 2 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip, Code) 18319 Oldtown Road, SE Oldtown MD 21555 Thomas Miller son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Iter any injury or oth Davis Memorial Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State 4/9/2007 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of unerall Service Lice Lee 22. Name Scarpelli Funeiral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Jant / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CARDIAL WK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the ası attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal deal 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.0. ed by the a detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page certificate 1∐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient ဥ 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) Injury 1 Natural 5 Pending To the rospinal within 24 hours after death. To the Funeral Director: Af 1 □ Yes 2 □ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical

(Check only one)

29b. Signature and title of certifier

Registrar

cona 31. Date filed (Month, Day, Year) APR 1 1 2007

Muny

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$2. Registrar's Signature

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D36766

29d. Date signed (Month, Day, Year)

Cumberland, MD 2150

Marshal

Thoma

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Year **Physician** Anyela Michelle Mattocks-Skanes 14400 5 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Cheverly Prince George's Hospital (corace If Under 1 Year If Under 24 Hrs. 8 Date of Birth (Month; Day, Birthplace (State or Foreign Country) 5. Social Security Number-6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 219 F Yrs. Director 1/and None
Usuel Residence of Decedent death with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Prince George's Directo Cheverly 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 3002 Brightseat Road 20706 United States Funeral Race - American Indian, Black, White, etc. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status e filed within 72 hours efter of Hygiene. other than "natural", or iten 1 Never Married 2 Married 1 ☐ Yes 2 Z No If Yes, Give X Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 end 2 should be fi Health end Mentel H om 27 is marked of Damiano William Mattocks Kamille Alicia Skanes permit. Pages 1 end 2 s.
Depertment of Health eno
important: if item 27 is ma
any injury or other reany injury or other re-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joan Davis/Aunt 11800 New Hampshire Avenue, Silver Spring, MD 20904 ce of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition
142 Burial 2 ☐ Cremation 3 ☐ Removal from State Place of Disposition (Name of cemetery, crematory or other place) National Harmony 3-26-2007 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Simple Tribute, 1040 Rockville 21. Signeture of Funeral Service Licensee Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in deeth) /Medical typerKalemia Examiner Due to (or as a consequence of): Examiner hemolysis use es the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest and Division of Vital Records, P.O. Box 68760. physician nivacrania Physician/Medical Due to (or as e consequence of) signed by the attending d be detached for use es Drematuri Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 20 No 1 Yes 1 Inpetient 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After t
completely filled in by the funeral To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier

Registrar

State

HOSPITAL PRIVE;

Chererly

Mary

30. Name end address of person who/completed cause of death (Item 23a) (Type, Print)

3001

32 Registrar's Signature

JENNINGS

31. Date filed (Month, Day, Year) MAR 2 8

Physician

/Medical

Director

Funeral

Completed

Be

Examiner

Funeral

Director

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ary	sho ma und h ma uma	ľ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (S	treet and Number or Ru	ral Route Numb
Ž	s 1 and 2 shoule f Health and Me tem 27 is mark other traumati		Marion Maus Greer	/Daughter	3412 Folly	Quarter Rd	Ellicot
5	jes 1 a t of Hea if item or othe		20a. Method of Disposition	20b. P	lace of Disposition (Name emetery, crematory or other		Date
Baltimore, Mary	Pages nent of int: If i		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specif</i>	Removal from State	st Lawn Mem.	Gard. 4-2-	2007
Balt	permit. Pag Deportment Important: I any njury o		21. Signature of Funeral Service Licer	MO10		Address of Facility Har d Columbia	
5			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	n. Do not enter the mode of	of dying, such as cardiac	or respiratory a
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pneum	roni'a		
8760,	Attending Physician: The law requires that the death certificate be executed refath. ector: After this certificate has been signed by the attending physician and property the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	Obstruc	tire Pull	ninar
P.O. Box 68760	w requires that the death certificenen signed by the attending to should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 ☐ Ectopic preg		
ds, P	uires that signed b d be deta	d by Pr	Part II. Other significant conditions of	contributing to death but not rest	ulting in the underlying cau	se given in Part I.	23e. Did 1
€00r	aw requisible been 2 should	plete	Dementia				24a. Was
al Be	: The l	Com					perfo 1□ Yes
#	ician sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Dea	th (Check only
7	hysi this c	은	1 ☐ Yes 2 ☑ No	1 Inpatient 2	ER/Outpatient 3 DOA		ome 5□Resi
ion	nding F ath. r: After e funera	ation:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	: Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe
Division or Vital Records,	i gitt	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory, o	office	28f. Location (City or To
	ie Hospital 24 hours a ie Funeral detely filled	dical (nysician: To the best of my kno miner: On the basis of examina and manner stated.			
	To the within 2 To the complete	Me	29b. Signature and the of certifier.	ian Mb		icense number 42892	
641)a2		30. Name and address of person who	completed cause of death (Item		- Patuxent	Park
-	,			W 1 1 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27 2007 MAUS MAR 9:45 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death County General Hospital Howard Howard (olumbia If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Months 1**X** M 2□ F Yrs. June 28,1920 214 26 7840 86 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No MD Sykesville Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13325 Forsythe Road 21784 United States 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 No
If Yes, Give
Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: þ White 3 Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Electrician Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Edward Maus Lilly Nesbitt er, City or Town, State, Zip Code) t City, MD 21042 20c. Location - City or Town, State Marriottsville, MD itzke's Family FH Inc. licott City, MD 21043 Approximate Interval Between Onset and Death days 23d. Date of delivery Month Day Year obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ormed? one) dence 6 Other (Specify) how injury occurred Street and Number or Rural Route Number, wn, State) cause(s) and manner as stated. date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Mar 2007

DHMH 17 Rev 1/2001

State Registrar Chuidian

State Registrar

31. Date filed (Month, Day, Year) AR 2 9 2007

MARK PÄRKHURST



3110

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Registra/Amend#1.PerPhys.PGC4-4-07cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 5:10 PM Charles William Matheson 2007 CHARLES WAYNE MATHESON mourch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F Director 578-36-6399 79 08-05-1927 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits nd other than "natural", or items 23a or 28a-f show event, the Medical Examiner πust be notified at 1 XYes 2 No Director Prince George's Maryland Berwyn Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 5801 Berwyn Road 20740 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. L 1215-0036

Leads 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked any injury or after 1 N Yes 2 No 1948 -1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Completed by 3 ☑ Widowed 4 ☐ Divorced White Year or Dates 1953 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Technician Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Matheson Katherine Arnold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne C. Matheson - Son 4200 Briggs Chaney Road, Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 03/29/2007 Silver Spring, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 MOIM91 Michelle 23a - art1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

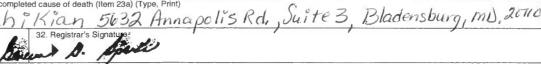
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MDD 34722

State Registrar

DHMH 17 Rev 1/2001

MAR 28 2007

Date filed (Month, Day, Year,



ress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** William Morris 22 2007 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sklisbury DICOMICO Medical ional Center eninsula If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 76 218-20-3182 4/28/1930 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show a or 28a-f sh t be notified a 1 ☐ Yes 2 X No Director Maryland Wicomico Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21875 USA 31500 Dagsboro Road 23a "natural", or items 23a death Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married Married 1 ☐ Yes 2 ☑ No white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mec College (1-4or 5+) Elementary/Secondary (0-12) Trucking Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Mary Frances Gordy Ralph James Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31500 Dagsboro Rd., Delmar, Joyce Ann Morris/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State 3/27/07 Salisbury, MD 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee 22 Harfin Address Futheral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 A Farial 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Septicemia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner pocket infection Pacer makes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Encepholopatt 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy perform certificate 2 No or Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Hospital or Attending 5 Pending investigation 1 🗷 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the ft. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the l within 2 29c. License number 29b. Signature and title of certifier 129105

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Registrar

CHRISTION HUDDLESTON 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI) 32. Registrar's Signature

100 E. Carroll ST. JALISBURY, Md. 21801

			. For	State of Maryla		ment of Health and	Mental Hygier	ne	
			For State Registrar		Certi	ficate of Death	Reg. I	No. 2007	11522
	Physici /Medio Examir	al 🕫	1. Decedent's Name (First, Middle, L Robert 4a. Facility Name (If not institution, g.	Lee M	Tilbo.	b. City, Town, or Location of Deat	3 20	Day Year 07 4c. County of Death	3. Time of Death
	Examir	ier	Peniosuus Regiona	1 11-11-1	ntu	SALISBURY		Nicon	rico
Sagital	Funeral Director			Sex 7. Age (In yrs		f Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthpl Coun	ace (State or Foreign try)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County Some 1 10e. Street and Number 2 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest generally/Secondary (0-12) 17. Father's Name (First, Middle, Last Balland) 19a. Informant's Name/Relationship 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify County Property	12. Was Decedent Ever in In Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates: 12 Yes, Give Year or Dates: 13 Yes 14 Yes, Give Year or Dates: 15 Yes, Give Yes, G	J.S. 13. Wa 168 15 16a. Deceder (Give kin life. DO S+Q+ 19b. Mailing 3 1890 Place of Dispositi	S Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puer I) Yes 2 No Specify: It's Usual Occupation of of work done during most of wo NOT use retired) 18. Mother's Na E	Specify Yes or Noto Rican, etc.) Trking The (First, Middle, Maidle,	14. Race - America Black, White, of Specify: Black, White, of Surname)	an Indian, atc. ACK Tustry Code) Md 2(8/4)
altii	permit. Page Department of important: If any injury or once.		21. Signature of Funeral Service Lic		22. N	lame and Address of Facility B	envie Jn	with Fund	seal Home
7,000	Physicián /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	a. Due to (or as a conse	quence of):	the mode of dying, such as cardia	c or respiratory arrest,	iry, MO	Approximate Interval Between Onset and Death
8760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a conse					
.O. Box 68	The law requires that the death certificate is the has been signed by the attending physionage 2 should be detached for use as the totals.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3□E	ctopic pregnancy tther (specify)		23d. Date of delive	ery Day Year
<u>α</u>	w requires that been signed by should be deta	by	Part II. Other significant conditions	contributing to death but not re	sulting in the unde	erlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
Vital Records,	Physician: The law r this certificate has be ral director, page 2 sh	Be Completed	25. Was case referred to medical examiner?	Hospital:	/	Othor	24a. Was an autopsy performed 1 Yes 2 1	? prior to condeath? 1 □ Yes	psy findings available npletion of cause of 2 No
Division or Vital	or Attending Phys ufter death. Director: After this in by the funeral dir	Certification: To	27. Mann of Death 1 Natural 5 Pending Investigati 3 Suicide 4 Homicide	28a. Date of Injury (Month, Day Year) be 28a. Place of injury. At	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in 28d. Location (Street City or Town, S.	njury occurred and Number or Rura	
	the Hospital hin 24 hours a the Funeral I mpletely filled	Medical C				ccurred at the time, date and place stigation, in my opinion, death occ			
)	To the within	Me	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month,	Day, Year)
١	1024		30. Name and address of person whe	o completed cause of death (Ite	em 23a) (Type, Pri	RROIL ST.	59/13h	uny m	35

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** 430 Arline H. Marvil narch 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOLISBUM cantu Peninsyun Regional Medical Hicimico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🔀 F 220-09-0332 90 Director Oct. 20, 1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1XXYes 2 □ No Director MD Wicomico Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 305 East Walnut Street 21875 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or I any injury or other traumatic event. the Median Extraction Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify. 3 X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) French Teacher High School 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arlie W. Hudson ပ Ethel Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30572 Paddington Court Salisbury, MD 21804

Date Date 20c, Location - City or Town, State Nola Arnold (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cemetery 3-30-2007 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home Delmar, DE 13 E. Grove Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARCINOMA LUNG MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 24a. Was an page 2 certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No P 1 Tyes 1 ■ Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death. Certification: Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) хотрletely filled in by 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D36576

560 RIVERSIDE DR SALISBURY MDOI

Registrar
DHMH 17 Rev 1/2001

State

RONALD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVITZ ND

32. Registrar's Signature

ÓRIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 10:50 P^M Marie Mader March 22 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick 1110 Sleighill Court Mt. 8. Date of Birth (Month, Day, Yea Aug. 2, 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 □ M 2 🕅 F Yrs. 1949 Director 219-48-9643 57 Canada Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryia Hygiene. othar than "natural", or Items 23a or 28a-1 shov ant, the Medical Examinan must to notified at 1 XYes 2 ☐ No Director Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 Sleighill Court 21771 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2 X No Yes, Give 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7 is markad othar traumatic avant, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If itam 27 is markad of ပ Charles Everett Dorothy Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If itam 27 is any njury or other traugues. John D. Mader / Husband 1110 Sleighill Court Mt. Airy, Maryland 21771 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) March 28, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Stauffer Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 2007 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of F 8 E. Ridgeville Blvd. Mt. Airy Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lie only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMONANY FAILURE disease or condition resulting in death) /Medical Examiner NON-SMACE CECC LONG CANCER Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Š signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ø autopsy performed? page 2 No 1 Tyes 2□ No Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ë this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) tha 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 035965 avel B. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B DAU 10 HARDINE mo MT. AIRY CENTER ST. #209

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month Day)

602

istrar's Signature

32. P

2007

			For State Registrar	State	of Maryla		artment of l		and Mer	•	giene Reg. No.?	ñ 7	11525
*	Physici	an	1. Decedent's Name (First, Middle		DCON MV	FDC				Date of Dea Month MARCH	-	ž ö 07	3. Time of Death 10:55 P M
ĵ.	/Medic		LORRAINE VERONI 4a. Facility Name (If not institution	n, give street and no	umber)		4b. City, Town,			HAROH	4c. Count	ty of Death	
-	Funeral		SOUTHERN MARYLA 5. Social Security Number	AND HOSPIT		TER I ast birthday	CLINTO	If Under	24 Hrs. 8.	Date of Birt	h	CE GE	ORGES Dlace (State or Foreign
L	Director		213-42-8290 Usual Residence of Decedent	1□M 2∏F	62	Yrs.	Months Days	Hours	Min. M	AY 25	1944	WASH	INGTON, D.C
	ryland how Lat	_	10a. State 10b. County			ity, Town or Lo						1	Od. Inside City Limits
	the Ma 28a-f s notified	Director	MARYLAND PRINCE 10e. Street and Number	GEORGES	F	ORT WAS	10f. Zip Code				10g. Citizen of	What Cour	1 XYes 2 No
	death with the Maryland ms 23a or 28a-f show r must be notified at		1605 HUNTERS MI					744			UNITED		
0030	be filed within 72 hours after death with the Marylan Ital Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Marr 3 □ Widowed 4 □ Divorced	ried Armed F	3. ⊼ No Bive		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No			/ Yes or No- an, etc.)	Speci	ace - Americ ack, White, ify: BLA	etc.
2	72 hou "natura adical E		15. Deceden (Specify only highe	t's Education st grade completed	1)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	ipation e during mos	t of working		16b. Kind of E	3usiness/In	dustry
7 7	d within glene.	Completed	Elementary/Secondary (0-12) 12TH GRADE	College	(1-4or 5+)		INISTRAT	-		NT	FEDERA	L GOV	ERNMENT
and	ld be filed lental Hygie ked other ic event, the	Be	17. Father's Name (First, Middle, JAMES L. WILKER								Maiden Surna URY WIL	,)N
Maryi	o⊓ Maria S	T ₀	19a. Informant's Name/Relations	hip (Type. Print)			ing Address (Stree	t and Numbe	er or Rural R	oute Numbe	er, City or Town	n, State, Zip	Code) 20744
e) E	Hea Hea		JAMES M. MYERS 20a. Method of Disposition	/ HUSBAN			HUNTERS osition (Name of or other plants)		AVENUE	<u> </u>	I WASHI 20c. Location		own, State
	0 0		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S				ETERANS CEM		1ARCH 30	,2007	CHELTEN		
Dall	permit. Pag Department Important: I any injury o		21. Signature of Fundral Service	Bunta	M00583	~ ²	THORNTON 3439 LIVI	FUNER NGSTOI	ÄL HOM N ROAD	E, P.	A. IAN HEA	D. MA	RYLAND 2064
	*		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	r complications that only one cause on	t caused the dea	ath. Do not en						.D, FIA	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	o (or as a conse								unknown
	Examiner	e.	Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury	0.	o (or as a conse	anun equence of):							in know y
	be executed ician and buriat-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
8/00,	ficate be execute physician and ts the burial-trans	dical E	,	d.	o (or as a conse	equence on.							
Ď	certificate Iding phys Ise as the	Ψ	IF FEMALE:	220 If yes o	outcome pf preg	2000							
.O. BOX	w requires that the death certifin been signed by the attending I should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	ebinth 2 □ Fe gnant at time of	tal death 3	⊒Ectopic pregnan ☐ Other (specify)	су				ate of deliv	ery Day Year
<u>ທຸ</u>	res that igned b be deta	by Pt	Part II. Other significant condition	ons contributing to	death but not re	esulting in the u	underlying cause g	iven in Part I					he cause of death?
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Vital	Physician: Th this certificate ral director, pag	o Be (25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hoepital:	₹Inpatient 21	TER/Outnatio	nt 3 DOA O		of Death (C		<i>ne)</i> dence 6 □O	Ab (Ci	4.1
П 0Г	ng Phy fter this ineral d		27. Manner of Death 1 Manual 5 □ Pendir	28a. Date	te of Injury onth, Day Year)	28b. Time (of 28c. Inju	ury at ork?	280		now injury occu		iy)
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director,	Certification:	2 Accident investigned investigation investigati	gation	ce of injury - At Iding, etc. <i>(Spe</i> d	home, farm, st	M 1 [Yes 2		Location (5 City or Tov	Street and Nun vn, State)	nber or Run	al Route Number,
	e Hospita 24 hours e Funeral	edical C		ng Physician: To the Examiner: On the and ma									
	To th withir To th comp	Me	29b. Signature and title of certifie		- M. P.		_	nse number	·		29d. Date sign	ned (Month, . 26.0	
(kR.		30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type	, Print)	a Suit	7-41	Silver	Sprin	MA	20901
Í	Sta		30. Name and address of person ROINTAN FAR 31. Date filed (Month, Day, Year) MAR 2	8 2007	P gistrar's Sig	nature	1	y	9 11		()	- 1-2
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07-02284		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Le	egible.					
Fimothy Musseln		1- For State Certificate of Death	Reg. No. 200	7 11520				
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) 2. Date of December 1. December 2. Date of December 3. Decemb	Dav Year	3. Time of Death				
Medical Examili	lei	Timothy Patrick Musselman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		2329 hrs				
		Union Hospital Elkton	4c. County of Dea	ın				
Funeral Director		Months Davis Nove Min	6, 1979 9. E					
auy	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits				
*	5	Maryland Cecil Rising Sun		1 X Yes 2 No				
Maryl 28a-f	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Co	untry?				
ith the Maryland 23a or 28a-f sho notified at once.	إة	3 Sun Valley Circle 21911	USA					
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - Ame White, etc.	erican Indian, Black,				
after d al", or	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Specify: (hite				
hours afte "natural", Examiner	힣	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)	16b. Kind of Business	/Industry				
	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Plastic Production	Plastics					
D 21215-0036 should be filed within 7 should be filed within 7 is marked other than 7 is marked other than antic event, the Medica	튅	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)						
	B B	Anthony Ray Musselman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numb						
D 21 should is ma atic ev	의	mber, City or Town, Sta	te, Zip Code)					
and 2 sho ealth and em 27 is	ŀ	Blythe Rose Wilson/Mother PO Box 774, Rising Sun, MD : 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date	21911 20c. Location - City of	r Town State				
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	-1	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 3-30-07						
nit. Pa arimer ortan	+	4 Donation, 5 Other Specify: R.T. Found Funeral Home, P.A. 21. Signature Funeral Service Licenses 22. Name and Address of Facility	Keseng Sui	r, Maryland				
Balt permit Depart Impor injury	4	21. Signate Funeral Service License () R. T. Foard Funeral Home 1111 S. Queen Street. Ris	, P.A. ing Sun, Mi	21911				
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and failure. List only one cause on each line.	rest, shock, or heart	Approximate Interval Between Onset and				
Examiner	1	Immediate Cause (Final disease or condition resulting in death)		Death				
	-	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						
	Guse Fnter Underlying Counce (Disease or injury that initiated events resulting in death) Last Underlying Counce (Disease or injury that initiated events resulting in death) Last Underlying Counce (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Last Underlying Councer (Disease or injury that initiated events resulting in death) Las							
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be execusician and	Physician/Medical	UNPENDED AMENDED		_				
Box 68760 e death certificate be the attending physi ed for use as the bu	ĕ[IF FEMALE: 23b. Was decedent pregnant in the 23b. Was decedent pregnant in the 25b. Was decedent pregnant in the 25c. If yes, outcome of pregnancy 25c. If yes, outcome of pregn	23d. Date of delive Month	ry Day Year				
x 68 th cert	icia Cia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	World	Day Total				
Bo he dea the a	چا	1 Yes 2 No 9 Unknown 9 Unknown		th				
ires that the signed by the detache	ह्य		obacco use contribute t s 2 ✓ No 3 Pre					
ords, w require as been sig	Completed			utopsy findings available				
COF s law r s has b	힐		ormed? death?	completion of cause of				
I Re n: The tificate or, pag		25 Was case referred to medical 26.Place of Death (Check only one)	2 No 1	es 2 No				
Vital Recc ysician: The lar his certificate ha director, page 2	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5	Residence 6 Oth	er;				
Division of Vital Records, spital or Attending Physician: The law requirements after death. Teral Director: After this certificate has been so filled in by the funeral director, page 2 should		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe	how injury occurred					
ttendi death.	읥	2 Accident Investigation Mar 24, 2007 2250 hrs						
lor A after Direction	Certification	Suicide 6 Could not be determined Constant Market	State)	ural Route Number, City				
Division Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	- 1	4 Momicide Continues To the heat of my keep ladge death population and along and due to the source	Circle, Rising Sun, N					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	(Check only one) 2 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.						
F × × ×	Me	29b. Signature and title of certifier 29c. License number	29d. Date signed (M	onth, Day, Year)				
		Carel Hallar O.C.M.E.	March 25, 2007					
3		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						

State Registrar

MAR 2 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		I-For State Amend Items 10 Registrar	a-f perent	ficate of	Death US/	O/gs/dhb	Re	g. No.	
Physicia	an/	Decedent's Name (First, Middle,Last)			-		Date of Deat Month	Day Year	3. Time of Death
Medical Exami	ner	William Richard	Mannin		D 03 T	Location of Death	March 7, 2	007	0255 hrs
		4a. Facility Name (if not institution, give street and Somerford Place of Hagerstown	riumber)		Hagerstowi			4c. County of D	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Yea		. 8. Date of Birt		9. Birthplace (State or
Director		551-18-1154 1XM 2			Months Day			F	oreign
	ŀ	Usual Residence of Decedent	6)	Yrs.	<u> </u>		Sep.6,	1921	CountryCaliforni
àue Au		10a. State 10b. County	10c. City, T	own or Locati	on 1				10d. Inside City Limits
* .	_	Florida Palm Beach Washington	Hage:	ratown La Beac	ch Garde	ens			1 X Yes 2 XNo
ie Maryland or 28a-f show fied at once.	Director	10e. Street and Number 125 Tost Br				33410-44	69	g. Citizen of What	Country?
5-0036 let within 72 hours after death with the Maryland ivgiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	ä	10114 Sharpsburg Pike			217			JSA	
with ms 23	ara		Decedent Ever in U.S			spanic Origin? (Sp			American Indian, Black,
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after ral",		3 X Widowed 4 Divorced If Yes, Give or Dates:			Yes 2 X No				White
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest of Elementary/Secondary (0-12) College	grade completed) e (1-4 or 5+)			tion (Give kind of v e. DO NOT use reti		16b. Kind of Busin	ness/Industry
36 iin 72 than '	ble	Elementary/Secondary (0-12)						Armtec	
5-003 iled withii Hygiene. I other th	틧	17. Father's Name (First, Middle, Last)	2	Const	ıltant	18.Mother's Name	(First, Middle, N		
	Be (William Lionel Manning				Phoebe R	ebecca I	Roberts	
	힏	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Stre	et and Number or F	Rural Route Num	ber, City or Town,	State, Zip Code)
e, MD I and 2 sho Health and item 27 is		Lisa Crytzer/Daughter		55 Isa	aiah Lan	e, Falli	ng Watei	s, West	Virginia
re, slan fHea fiter rertra		20a. Method of Disposition 1 XBurial 2 Cremation 3 Remove	20b. Pl	ace of Disposi ematory or oth	tion (Name of ce er_place)	metery,	Date	20c. Location - Ci	•
more Pages 1 nent of H ant: If i		4 Donation 5 Other Specify:	Arl	ington Cemete	erplace) Nationa Ty	.l May	28,200	Arlingt	on, Virginia
Baltimore, permit. Pages I ar Department of Hes Important: If ite	Ì	21 Signature of Funeral Service Licensee	•	22. N	ame and Addres	s of Facility ING FUNE	RAT. HOMI	I. INC.	
		Wast Timb		17	'l W. Ma	ple Ave.	, Vienna	ı , Va. 22	180
Physician / //////////////////////////////////		23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.					r respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death
Examiner			sclerotic ca		cular dise	ease			Deatri
		b	as a consequence of):						
	ē		as a consequence of):				-		
Q.	Examiner	C. Disease or injury that initiated	as a consequence of):						
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687 ertific ding p		past 12 months:	ve birth egnant at time of dea	th =		Ectopic pregna	ancy	Month	Day Year
Box 68's death certificate attending	/sic	1 Ves 2 No 0 University	nknown	th 5 Ot	ner (Specify)				
b.O. Box that the death red by the att	by Physiciar	Part II. Other significant conditions contributing	ng to death but not res	sulting in the u	nderlying cause	given in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
Division of Vital Records, P.O. Ital rate death. Is after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detected.	ğ						1 Yes	2 No 3	Probably 4 🗸 Unknown
rds, requir	Completed						24a. Was autop		ere autopsy findings available or to completion of cause of
CO lee law lee has ge 2 sl	d				-			med? dea	eth? Yes 2 No
tal Rectinan: The certificate ector, page		25. Was case referred to medical			26.Plac	e of Death (Check			7 100 1 10
Vita ysicia his cel direct	o Be	examiner? 1 ✓ Yes 2 No	/ Inpatient 2	ER/Outpatient	3 DOA	Other Nursi	ng Home 5	Residence 6	Other:
n of ding Ph	.T	27. Manner of Death 28a. D	ate of Injury lonth, Day, Year)	28b. Time of I		ury at Work?	28d. Describe I	now injury occurred	
ion tendii tor: A	ţį	1 X Natural 5 Pending	, 2 2,, 1 2 2.,		1	Yes 2 No			
ViSi or Att fiter d Direct in by	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. F	Place of Injury - At hor	me, farm, stree	et, factory, office	building, etc.	28f. Location (S		or Rural Route Number, City
pital Dital	Certification:	4 Homicide determined (Spec	cify)						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier (Check only one) 2 Medical Examiner: On the ba	best of my knowledge	e, death occur	red at the time, o	date and place, and	d due to the caus	e(s) and manner a	s stated
To the Ho within 24 h To the Fur	Medical	and mann		uror investigat		se number	at the time, date		(Month, Day, Year)
	2	29b. Signature and title of certifier				.M.E.		April 4, 2007	
		unete		-		.1¥1.∟.		7 10111 4, 2007	
ϕ		 Name and address of person who completed Ana Rubio MD. Assistant Medic 			Street. Baltim	ore, MD 2120	1		
	tate		Registrar's Signatur		M				
3	خلاند	APR'1 T' 7007	Par 180 1 180	Chroson	81.3				

			1 - For Amend per DR Part State Amend Line 31 p	State of Man II KG er Health Der	yland / Depa ot KG <i>Ce</i>	artment o	of Health of Death	and Men	tal Hygi	ene	07	11528				
	Physici	an	Decedent's Name (First, Middle, Last)						Date of Death Month	Day	Year	3. Time of Death				
NGL	/Medic		DONALD OWEN NASH,					RCH	20,	2007	1637 ^M					
	Examin	er	4a. Facility Name (If not institution, give s				n, or Location	of Death		4c. County						
		100	1613 CHESTER DRIVE 5. Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Y	STER ear If Under	r 24 Hrs. 8 C	Pate of Righ	QUEEN						
	Funeral Director		214-30-5110 10X	[M 2□F	73 Yrs.		ays Hours	Min. (Date of Birth Month, Day, LY 15,	1933	MARY					
	land		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town or Lo	ocation					1	0d. Inside City Limits				
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	r 28a	irec	10e. Street and Number	AL D	TILD LLIK	10f. Zip Coo	de		10	g. Citizen of	What Coun	itry?				
	th wit	aiD	1613 CHESTER DRIVE			2161	9			USA						
	eme eme	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent	of Hispanic Or Cuban, Mexica	rigin? (Specify an, Puerto Rica	Yes or No-		e - Americ ck, White,					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-f show any fujury or other traumatic event, the Medical Exa-ill at maral be notified at ODGE.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ▼ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:		1⊡Yes 2🛚			,,		v: WHI					
21215-0036	2 hou	ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Od	ccupation		1	6b. Kind of B	usiness/Inc	dustry				
215	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	e kind of work done during most of working DO NOT use retired)										
21	giene giene	Com	10	College (1-401 3+)	BRICI	C STONE	MASON		C	ONSTRU	CTION	ſ				
Maryland	al Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Moth	er's Name (Fir	st, Middle, M	aiden Sumar	ne)					
<u>ya</u>	Meni Meni arke	٩	WILLIAM E. NASH, SR	₹.			LAUI	RA V. W	ILSON							
Jar	2 sh and Is m	W.	19a. Informant's Name/Relationship (Typ			•		er or Rural Ro				•				
e,	1 and 4ealth 9m 27 ther t		KAREN NASH JONES/DA		132 K 20b. Place of Dispo	IDWELL	AVENUE	P.O. B				LE MARYLAND				
Baltimore,	if its		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	emoval from State	cemetery, crei	natory or other	place)	MARCH	22,	Oc. Location	,					
Ë	rtmer rtent njury		4 □Donation 5 □ Other (Specify) 21. Signalum of Juperal Service License		CHESAPEAK			2007				, MARYLAND				
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di,			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on-	cations that caused the e cause on each line.	e death. Do not ent	er the mode of	dying, such as	s cardiac or res	piratory arres	st,		Approximate Interval Between				
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	/Medical Examiner		resulting in death)	Due to (or as a co	Due to (or as a consequence of): (grange Atheros Clerosis											
	LXdiffiller	_	Sequentially list conditions, b	Car				years								
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of): Due to (or as a consequence of):								0				
	and and II-trar	xan	that initiated events c. resulting in death) Last													
8760,	cate be executed physician and the burial-transit															
687	phy phy the	edical	d.													
X	that the death certifed by the attending detached for use as	M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p	pregnancy	-				23d. Da	te of delive	ry				
P.O. Box	death e atte	ciar	Physician/Me	icia	icia	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 □ 4□Pregnant at tim		Ectopic pregna Other (specify						Day Year
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	The law requires that the death certif te has been signed by the attending page 2 should be detached for use as	by P	by P	oy P	by P	by P	Part II. Other significant conditions cont	tributing to death but n	ot resulting in the u	nderlying cause	given in Part	I.	23e. Did toba	acco use cont	ribute to th	e cause of death?
Zd	w requir been si should		- Valgaris						1 Yes	2 □ No	3 Prob	ably 4 ⊡Unknown				
Ö	law r as be	pie	Ety perta	m) un		24a. Was an autopsy	24b.	Were autop	osy findings available inpletion of cause of							
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S	death death stor:	Icat	2 Accident investigation 3 Suicide 6 Could not be	20 a Plana of Injury	At home form at		1 Yes 2		anation (Ctoo							
Division of Vital Records,	al or Attents after death	Certification;	4 ☐ Homicide determined	28e. Place of Injury building, etc. (5		eet, factory, off	ICO	281. L	Dity or Town,	State)	er or Hura.	l Route Number,				
	To the Hospital or Attending Physician: which 24 hours after death as a fire death To the Funeral Director: After this certifica completely filled in by the funeral director; p	edicai (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examining	ician: To the best of mer: On the basis of example and manner stated	amination and/or in	occurred at th	e time, date ar ny opinion, dea	nd place, and c ath occurred at	lue to the cau the time, dat	use(s) and ma e and place,	inner as st and due to	ated. the cause(s)				
	vithin 2 To the complet	ž	29b. Signature and tittle of certified	· · · · · · · · · · · · · · · · · · ·			ense number		290	d. Date signe	d (Month, I	Day, Year)				
	•		1 bunk			D.	37064			3/22	107					
			30. Name and address of person who com	mpleted cause of death	(Item 23a) (Type,				MD	2166	6					
	Sta	te	31. Sate filed (Month, Day, Year)	32 Registrar's	Signature	-										
	Registr		FEB 2 2 200	7 Decer	15 Ap	362										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 200 40 Joseph Harle O'Brien LARC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomica SAlisbury Regional Medical If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, You Feb. 23, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year 1⊠M 2□F 219-12-5864 Director 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Items 23a or 28a-f show 1 X Yes 2 No Maryland Dorchester Hurlock. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21643 306 South Main Street USA Funeral Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S.
Armed Forces? 1943—
1 XYes 2 No 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 0 s, Give 1 ☐ Yes 2 🗓 No 1946 Specify. δ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Telephone College (1-4or 5+) Office Worker Manufacturing is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard O'Brien Elizabeth Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. Josephine S. O'Brien/Wife P. O. Box 630, Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation Maryland Veterans Cem. 3/29/2007 Beulah, Maryland 4 ☐ Donation → ☐ Other (Specify 21. Sign, ture of Funeral Service Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final otic Physician dans disease or condition resulting in death) /Medical r as a consequence of): Due to (Examiner eumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the buriat-trans Due to (or as a consequence of) Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760.

Registrar

20b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carrell

100 E

29c. License number

29d. Date signed (Month, Day, Year)

Mar 26, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 2245 26, Viola Margaret Owens March 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grant Min. | 8. Date of Birth (Month, Day, Year) Oct. 18, 1 Harford Memorial Hospital Harford 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ☑ F Maryland 78 1928 220-24-2513 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show troumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Maryland Perryville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 21903 U.S.A. 344 Jackson Station Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 □ Divorced Year or Dates: naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7: h and Mental Hygiene. 7 Is marked other then "n V.A. Medical Center Elementary/Secondary (0-12) College (1-4or 5+) Perry Point, Maryland Twelve Years Supervisor Housekeeping Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Dominic Bungori Jessie May Hipkins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Department of Health a Important: If Item 27 is any injury or other tre once. (son) 328 Jackson Station Road, Perryville, MD Walter J. Owens, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/30/07 Perryville, Maryland Principio Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lee A. Patterson & Son Funeral H. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Plecer WK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Aorli signed by the attending physician and the detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical The law requires that the death certificate 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmeg? 2∰ No certificate 1 ☐ Yes of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After 1 Delatural 5 Pending investigation s after de... 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funaral I 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MM Wham

Registrar

State

1106 Revolution

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month Day, Year)
MAR 2 9

Milhamans

32 Registrar's Signature

	land	wo	7	31
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Donadment of Health and Marial Huriana	Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show	any injury or other treumatic event, the Medical Examiner must be notified at	
Baltimore, I	permit. Pages 1 and	Important: If item 2	any injury or other i	once.

ROSALIE PRICE

For

		- State Registrar				Cei	rtificate	of D	eath	F	Reg. No.				
		1. Decedent's Name (First, Mi	ddle, La	ist)		-	-			2. Date of Dea			3. Time of Death		
Physicia		ROSALIE PRIC	T							Month MARCH	Day 2 .		11:10AM		
/Medic		4a. Facility Name (If not institu		re street and n	ımber)		4b. City. To	own. or l	ocation of Dea			County of Death	11.10M1		
Examine	er .	29352 GREENF											OTT		
		5. Social Security Number		Sex	7 Ago (In use	. last birthday)	If Under 1		APPE If Under 24 Hr	s. 8. Date of Birt		TALB			
Funeral	İ			1 □ M 2 □ X F	70	Yrs.		Days	Hours Mir		Year)	9. BIRTID	lace (State or Foreign try) LAND		
Director	-	212-40-9952 Usual Residence of Decedent			70	110.				DEC 0,	193	O MAKI	LAND		
and *	ŀ	10a. State 10b. Cou			10c, C	ity, Town or Lo	ocation					11	0d. Inside City Limits		
larylan show	5	MD T	ALB	OTT		TRAPI							1 Yes 2 □ No		
the Mi	Director		ALD	<u> </u>		IKAPI									
or 2	5	10e. Street and Number					10f. Zip C	ode			10g. Citi:	zen of What Coun	try?		
72 hours after deeth with the Maryland natural; or Items 23a or 28a-f show dical Examinar must be notified at	60	29352 GREENF	IEL	D AVE.					21673			USA			
ee E	Funeral	11. Marital Status		12. Was Dec	cedent Ever in U	J.S. 13.	Was Deceder	nt of His	panic Origin? (Specify Yes or No- into Rican, etc.)	. 1	14. Race - Americ			
after or Ite		1 Never Married 2 N	Married	1 Tes	2 X No		-			ito rican, etc./		Black, White,			
hours :	۾	3 ☐ Widowed 4 🌠 Divor	bed	If Yes, G Year or I	ive Dates:		1 ☐ Yes 2	No	Specify:			Specify: WHI	TE		
natur	Completed	15. Dece	dent's E	ducation		16a. Dece	dent's Usual (Occupat	ion		16b. Kir	nd of Business/Inc	lustry		
C * 86	8	(Specify only hig				(Give	kind of work DO NOT use	done du retired)	iring most of w	orking			•		
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d de	Be	ALEXANDER GR		,								·			
should I	၉									E MAE WHE					
s 1 and 2 should be filed within if Health and Mental Hyglene. Item 27 is marked other than other treumatic event, the Mental in	-1	19a. Informant's Name/Relation	onship (Type, Print)		19b. Mailir	ng Address (S	Street a	nd Number or F	Rural Route Numbe	r, City or	Town, State, Zip	Code)		
and ealth m 27		MARVIN J. PR	ICE,	/SON		3610) WARW	ICK	RD., EA	AST NEW M	ARKE	T, MD 21	631		
of He of He fitem		20a. Method of Disposition				Place of Dispo			1	Date	20c. Lo	cation - City or To	wn, State		
		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery, crematory or other place) SPRING HILL CEMETERY 3/29/2007 EASTON. M										amorr 100			
rtan	-	21. Signature of Funeral Serv	HILL CEMETERY 3/29/2007 EASTON, MD 22. Name and Address of Facility												
permit. Page Department of Important: If any injury of once.		21. Signature of Furieral Serv	CO LICO				TELT.OWS	S. H	ELFENRI	IN & NEW	MAM	FIINERAT.	HOME PA		
2223	-	NOHN	*		RCE	(O) 2	200 S.	HAR	RISON S	T EASTON	, MD	21601			
_		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Cause on each line.													
Physician		Immediate Cause (Final disease or condition		21	latte	1			Onset and Death						
/Medical		resulting in death)		Due to	(or as a conse	quence of):	andi	01	ragor	Line			Jews		
Examiner									/ /	0			U		
	ē	Sequentially list conditions, if any, leading to immediate		b. Due to	(or as a conse	quence of):									
pe tist	듣	cause. Enter Underlying Cause (Disease or injury	≺												
certificate be executed ding physician and se as the burial-transit	Examin	that initiated events resulting in death) Last		C											
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	_	IF FEMALE: 23b. Was decedent pregnant			tcome of pregn]c				2	3d. Date of delive	ry		
death of attended for u	<u>0</u>	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐ Preg	birth 2 🗍 Fet nant at time of t]Ectopic preg] Other (spec					Month	Day Year		
The law requires that the death Ne has been signed by the atter bage 2 should be delached for t	Physicial	9 🗆 Unknown		9□ Unkr	nown										
that ed b deta		Part II. Other significant cond	fitions	contributing to	teath but not re	sulting in the u	nderlying cau	ise giver	in Part I.	23e. Did to	bacco us	se contribute to th	e cause of death?		
sign Sign	۵	Time TI	20	beter	2-11	10. tu	1 1	مهدد از	1	iay	- 4	/			
w require	e e	19 ged napeus much with							Ch	101		2 No 3 □ Probably 4 □Unknown			
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	9	25. Was case referred to med	ical	K 1/2	ville	ar 10	usua	se	OC Place of D		<u> </u>	No 1 Yes 2 No			
Attending Physician: rr death. ector: Atter this certifice by the funeral director, f	O	examiner? 1 ☐ Yes 2 ☑ No		Hospital:	Innation: 05]CD/O:+ :		Other	,	eath (Check only or					
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r At ter d rect		3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide deta	emined	200. Fiau	e of Injury - At h	nome, farm, str	eet, factory, o	office		28f. Location (S City or Tow	treet and	d Number or Rura	Route Number,		
Hospitel or Attending 24 hours after death. Funeral Director: Attending stell filled in by the fun	Certification										/				
pspi nour y fills		29a. Certifier Certifier	lying Pl	nysician: To th	e best of my kn	owledge, death	occurred at	the time	, date and place	e, and due to the o	ause(s)	and manner as st	ated.		
H 24 24 Fr	dicai	(Check only 2 Media	al Exa	miner: On the l	pasis of examination	ation and/or in	vestigation, in	n my opi	nion, death occ	curred at the time, o	ate and	place, and due to	the cause(s)		

Division of Vital Becords, P.O. Box 68760

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



MAR 2 B 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0053602

29d. Date signed (Month, Day, Year)

		1 - State Registrar		Cei	rtificate of			g. No.				
Physic /Medi		Decedent's Name (First, Middle, Last LAWRENCE RICHAR)				2. Date of Death Month MARCH	Day Y	3. Time of Death				
Exami		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of	Death			
		TALBOT HOSPICE	HOUSE		EASTO	N		TALI	ВОТ			
Funeral		Social Security Number 6. Se	x 7. Age (In X	yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day,	Year)	Birthplace (State or Fore Country)			
Director		213-30-7406	54	Yrs.		N	OV. 5,	1952	MARYLAND			
and w		Usual Residence of Decedent 10a. State 10b. County	100	: City, Town or Lo	cation				10d. Inside City Lim			
72 hours after death with the Maryland naturel', or Iteme 23a or 28a-1 ehow dical Evantinar must be notified at	ō	MD TALB	ОТ	TRAI	PPE				1 Tes 2			
the 28s	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?			
3a o		3896 CLORA DORSE	▼ ROAD			21673			USA			
100 and 100 an	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of I	Hispanic Origin? (Spec ean, Mexican, Puerto R	fy Yes or No-		American Indian,			
owining 12 hours are death with the ways gine. Then "naturel", or leame 23e or 28e-1 e hov the Medical Exertical must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		1 Yes, specify Cub 1 ☐ Yes 2 🌋 No		can, etc.)	Specify:	WHITE			
atur	Completed by	15. Decedent's Edu (Specify only highest grad	ucation		dent's Usual Occup		1	6b. Kind of Busi	ness/Industry			
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Hygiene. other than " ent, It a Mes	5	12	5+	ASST.	. STATES	ATTORNEY		TALBO:	T COUNTY			
_ 0 5	Be (17. Father's Name (First, Middle, Last)	-			18. Mother's Name (
	2	LAWRENCE RICHARD	PERRY, SR.				WILLIS					
th ar		19a. Informant's Name/Relationship (T) CHRISTINA S. PER				ORSEY RD.,						
T OF		20a. Method of Disposition	I	b. Place of Dispo	sition (Name of natory or other pla	Da	te 2	Oc. Location - Ci	ity or Town, State			
		1 ☐ Burial 2 T Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State			TION CTR 3/	26/2007	STEVE	NSVILLE, MD			
orts		21. Signature of Funeral Service Licens	see	22	Name and Addre	ELFENBEIN	s. Mirlini A	M EIMED	AT HOME DA			
		TOHOR !	MERCER		00 S. HAF	RRISON ST E	ASTON,	MD 2160	1			
		23a. Part1. Enter the disease, or comp	lications that caused the						Approximate			
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kaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of: Cerebral Edon Due to (or as a consequence of: Cerebral Edon Due to (or as a consequence of: Cause. Enter Underlying Cause (Siesase or injury)										
-	je	Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):					x weeks			
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ian a	EX	resulting in death) Last	D o (or as a cor	sequence of):								
hysic he bi	edical		d									
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attanding for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐	у		23d. Date of						
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ed by the detached	Phy	9 Unknown					T					
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S CI	Completed						24a. Was an autopsy	pric	ere autopsy findings availa or to completion of cause			
pag	Sol						perform	ed? dea	ath?]Yes 2□ No			
certific rector,	Be	25. Was case referred to medical examiner?				26. Place of Death (Check only one	1				
.≅ .⊟	2	1 ☐ Yes 2 ☑ No		2 ER/Outpatien	JU DON		5 ☐ Resider	nce 6 Other	(Specify) HOSPICE			
n. After th funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injur	ry at 28	d. Describe how	w injury occurred	1			
	Certification:	2 ☐ Accident investigation			M 1	Yes 2 □ No						
Director:	Ę	3 Suicide 6 Could not be 4 Homicide determined	28	281. Location (Street and Number or Rural Route Number, City or Town, State)								
ed in												
within 24 hours effer of the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exama	sicien: To the best of my mer. On the basis of exar	knowledge, death	occurred at the till vestigation, in my o	me, date and place, an opinion, death occurred	d due to the cau	use(s) and mann	ner as stated. d due to the cause(s)			
ple	Med	oney	and manner stated.									
- =	-	29b. Signature and title of certifier		10	29c. Licens	se number	29	a. Date signed (Month, Day, Year)			
Com			m			1000	1V	Ianch	~0, ~UU			
Tot		Seymo					1					
TA-		30. Nam, and address of person who co		(Item 23) (Type,	Print)	1110		Dal	70 . 116			
JA		30. Nam, and address of person who co	ompleted cause of death	505/1	Print)/EW	Id Ave	nve,	East	26,200°,			
JA	ate		ompleted cause of death 32. Registrar's S	50) / (signature	Print)/ewi	Id Ave	nve,	East	m, Me			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 03 2007 0205 KATHERINE PATTERSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CAROLINE DENTON CAROLINE NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** 1 M 2 XF Director 91 06-13-1915 Maryland 126-20-7074 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Medical Exempler must be notified at 1 Yes 2 No Director Delaware Kent Dover 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 19904 24 N. Oueen Street Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or then any injury or other treumatic. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify Completed by Black 3 ₩Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Someone else's home Home maker 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sarah Wilson Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24 N. Queen Street, Dover, Delaware Alice M. Brown / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 04-07-07 Grennsboro, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) Coker's Cemetery 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Signature of Furieral Service Licenses rince 717 W. Division St., Dover, Delaware 19904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician heimer's Means resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician Division of Vital Records. P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctooic pregnancy Month Year Day in the past 12 months?
1 Yes 2 No director, page 2 should be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 2 🗆 No 1 Yes 2 No 1 TYes To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 3 □ DOA Other: 4 Nursing Home 5 □ Residence 6 □Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie DO047534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 Market St. Denton, MD 21629 ZaKi MD 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 2 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 23, 2007 9:12 p^M Paul Ernest Pierson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F March 8, 1920 022-14-1008 87 Massachusetts Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits show items 23a or 28a-f shorner must be notified at 1 ☐ Yes 2 No Directo Montgomery Silver Spring Maryland 1 4 1 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 20904 U.S.A. 13612 Wendover Road Examiner must Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Defense & Research is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Signe Christina Olson Ernest Felix Pierson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Pierson - Spouse 13612 Wendover Road, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Cedar Hill Cemetery 3/29/2007 Suitland, Maryland 21. Signature of Funeral Service Vicenia e 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Patt1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-tran and Due to (or as a consequence of) attending physician Physician/Medical as the l IF FEMALE: nse If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Donknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an has performe certificate 2 Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/21/10 1 Hipatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the

Box 68760 P.O. I Records, or Vital Division

or Attending death. within 24 hours after death To the Funeral Director: Hospital within 24 To the

> State Registrar

Medical

address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

31 Date filed (Mr.

29b. Signature and title of certifier

egistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dav. Year)

		1	For State Registrar	State of	of Maryland / [rtment of H tificate of L		nd Me		jiene eg. No.	Total log of	11535	
	.		1. Decedent's Name (First, Midd.	le, Last)					2	2. Date of Dea		Year	3. Time of Death	
	Physicia /Medic		Elsie Emma	Parr						Warel	1 23.	2007	7.55 PM	
	Examin		4a. Facility Name (If not institutio	n, give street and nu	umber)		4b. City, Town, or	Location of	f Death		4c. County			
			Holy Cross Rehad	and Nursing				nsville			100	omery		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs. last bit	rthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day	Year)	Coun	nlace (State or Foreign ntry)	
	Director		215-10-7591	1	91	115.]1	December	22,1915	Mary1	and	
	and w	H-	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Tow	n or Lo	cation					1	0d. Inside City Limits	
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	the t	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cour	ntry?	
	3a or		1860 A Queen E	lizabeth Dr	ive		20	833			U.	S.A.		
	ms 2	Funerai	11. Marital Status		cedent Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Orig	gin? (Spec	ify Yes or No-		e - Americ		
9	within 72 hours after death with the Maryland one. Than "neturel" or Items 23a or 28e-f show the Macical Examirer riust by notified at		1 Never Married 2 Mar		2 🔀 No		Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	iouri, oto.,	Specif		oto.	
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2	be filed within 72 hours after death with the Marylan Hygiene. d other than "neturel; or Items 23a or 28e-f show event, the Macical Examiner rust be notified at		12 17. Father's Name (First, Middle	(ast)			Salesperso		r's Name	(First, Middle,	Maiden Surnar			
anc	be fi	Be					1			. Staff		-,		
Maryland 21215-0036	2 should be i and Mental I Is marked o eumatic eve	2	Emanue1 J. 19a. Informant's Name/Relation		191	n Mailin	g Address (Street :				per, City or Town, State, Zip Code)			
Ma	d 2 sl th an 7 Is r treur									hland, Maryland 2077				
e,	1 an Heall em 2	1	David A. Par 20a. Method of Disposition	r - 3011	20b. Place of	of Dispo	sition (Name of		Da		20c. Location		own, State	
٥	ages nt of nt of t: If it		1 Burial 2 Cremation		n State		natory or other plac		3/30/:	2007	Cilver C	nring	, Maryland	
Baltimore,	it. P.		* 4 ☐ Donation 5 ☐ Other (Gate o	- 1	aven Cemete Name and Addres	100		2007	PITAGE	hrring	, that y land	
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic edgnes.	Mylin Welen Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Sil									Iver Spring, Marvland 20904 Approximate			
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	/Medical Examiner	resulting in death) Due to (or as a consequence of):												
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	ed sit	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	₹	to (or as a consequence or).									
_	and and Il-trar	Exami	that initiated events resulting in death) Last	c	o (or as a consequence	as a consequence of):								
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	eath certific attending p I for use as I	×	IF FEMALE: 23b. Was decedent pregnant		outcome of pregnancy		7				23d. Da	ate of deliv	ery	
Вох	atter of for u	Physician/M	in the past 12 months?	4□Pre	e birth 2 □ Fetal deat gnant at time of death		Ectopic pregnancy Other (specify)				М	onth	Day Year	
O.	t the de by the tached	ıysi	9 Unknown	9□ Unl	known									
0	that hed b		Part II. Other significant condit			in the u	nderlying cause giv	en in Part I		23e. Did te	obacco use cor	tribute to t	the cause of death?	
rds	quires n sign uld be	q p	GANGRE	NE R) toot					1 🗆 1	res 2□No	3 🗌 Pro	bably 4 Onknown	
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ta		a)	25. Was case referred to medic	al	26. Place of Death					ath Check only one				
		0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	☐Inpatient 2☐ER/C	utpatier	nt 3 DOA Oth	er: Nu	rsing Hom	ne 5 ☐ Resid	dence 6 □Ot	her (Speci	ify)	
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	s afte	Certification;	4 _ Homous	50.	iamig, etc. (opcony)				1					
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certify (Check only 2 Medical	ring Physician: To t	the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. It basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								stated. to the cause(s)	
	the H in 24 the F plete	Medical	one)	and ma	anner stated.									
	To t To t	Σ	29b. Signature and title of certif	ier /			29c. Licens				29d. Date sign	ea (Month,	, vay, rear)	
)	20		Jaeneer	u Vall	wown n	m)	285	17	A		5/2	1107		
	-		30. Name and address of person	/	use of death (Item 23a	(Type,	Print)	El F.	QAC:	ro n	w 21	209		
			TASNEEM 31. Date filed (Month, Day, Yea	CARHAI 3	Registrar's Signature	00								
	2.17	ate	MAR 2 8		La .	1	AS .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 5:31 PM MARCH 2007 27 Charles Allen Phillips, Sr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) SAINT AGNES HOSPITAL BALTIMORE None If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 1,1939 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Days 1 XM 2 ☐ F Ohio 67 294 34 5520 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21228 14 Heather Hill Rd 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1957–61 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor US Food Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Ward William B. Phillips 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14 Heather Hill Rd Catonsville, MD 21228 Ruth Joyce Phillips/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 3-28-2007 Catonsville, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Shew Collis u 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA WEEKS Due to (or as a consequence of) ANEURYSM NEARS ABDOMINAL AORTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) YEARS CONGESTIVE HEART Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Xyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 X Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

the death certificate be executed

P.O. Box 68760,

Charles

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

MD

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after on and Mental Hygiene. is marked other than "natural", or Itel

Pages 1 and 2 ment of Health a ant: If item 27 is

Injury or Department of Important: If any Injury or once.

altimore, Maryland 21215-0036

death v

Examiner as the burial-trai use for

physician Physician/Medical After this certificate has been signed by the funeral director, page 2 should be detached Be Completed by

Medical Certification: To

(ot) 02

Division or Vital Records, or Attending 24 hours after death Funeral Director: filled in by Hospital completely within 24

> 31. Date filed (Month, Day, Year) State Registrar

IF FEMALE 9 Unknown examiner'

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

27. Manner of Death

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

19384

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2007

MARCH 27,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

BALTIMORE, MD. 21729

M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

FRANCO GUSTAVO

MAR 2 9

900 S CATON AVE,

32. Resistrar's Signature

Examiner Box 68760. Division or Vital Records, P.O.

The law requires that the death certificate be executed bunal-transit and attending physician for use as the buna signed by the a page 2 s has certificate al or Attending Physician; this after death.
I Director: After the in by the funeral

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event

Physician

/Medical

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72 hours after death Items 2

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Maryland 21215-0036

Baltimore,

Examiner must be notified

	To the Hospii within 24 hour To the Funer completely fills
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tate legistrar

Medical

29a. Certifier

29b. Signature and title of certifier

NAR 28 2007

706		
30. Name and address of person who	complete	ed cause of death (Item 23a) (
Uchechi 7.0	page	beogy, mb
31. Date filed (Month, Day, Year)	A 50	32. Registrar's Signature
44 n o o o ono7	24.5	A Active

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, You 03-26-7007)

Type, Pring Oxon Hill Rd# Fol, Oxon (Kil, MD 20745

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Ma	aryland /		rtmen tificate				R	eg. No.	200	1	338
	Physici		1. Decedent's Name (First, Middle, Las Harry Alton	t)	Patter	son	Jr.			2	2. Date of Dea Month March		200 ^{Year}	3. Time of D 4:.05	Peath M
	/Medio Examir	_	4a. Facility Name (If not institution, give						Location of	Death			ounty of Dea		
	Funeral Director		1814 Mt. Hermon 5. Social Security Number 6. Social Security Number 6. Social Security Number	7. Ag	e (In yrs. last i	birthday) Yrs.	Sall Il Under Months	Sbur 1 Year Days	II Under 2 Hours	Min.	3. Date of Birth (Month, Day 8/25/19	Year)	Wicom: 9. Bir	thplace (State or lountry) cyland	Foreign
	e Maryland	Director	Usual Residence of Decedent 10a. Slate Maryland Wicomi	co	10c. City, To	own or Lo								10d. Inside City	
	with th	al Dire	10e. Street and Number 1814 Mt. Hermon	Road			10f. Zip	code 21804	ļ		1	0g. Citize USA	en of What C	ountry?	
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itsm 27 is marked other then "netural", or items 23e or 28e-1 show or other traumatic svent, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates	Vo.		Vas Deced Yes, spec			in? (Speci Puerto Ri	ify Yes or No- can, etc.)		Race - Ame Black, Whi	erican Indian, te, etc. white	
21215-0036	filed within 72 h Hygiene. Other then "netu ent, the wedice	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5		(Give	OO NOT us	rk done du se retired)	uring most		7	Pr	of Business	/Industry	
Maryland	should be fill nd Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last) Harry Alton Patt	erson Sr.							First, Middle, I Carver	Maiden S	umame)		
	and 2 sho lealth and m 27 is m		19a. Informant's Name/Relationship (7 Betty Jane Patter	•		1814	Mt.	Herm		1., s	Route Number alisbur	у, М	ID 2180)4	
Baltimore,	Pages 1 ment of H ent: If Its ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place ceme Sprip	tery, cren	natory or o	ther place		Da 3/29/			oron, N	Town, State	
Balt	permit. Page Depertment Importent: If sny Injury or once.		21. Signature of Funeral Service Lices	un		22 H	OITO	d Address	of Facility unera III R	l Ho	me Prof Salisbu	essi ry,	onal A MD 218	Associati 304	ion
	Physician /Medical		23a. Part1. Enter the disease, or come shock, or heart failure. List only disease or condition resulting in death)	one caŭse on each lin	10.			•		ardiac or	respiratory arr	est,		Approximate Interval Belwe Onset and De	ath
8760,	ate be executed hysicien and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.	a consequence	(C 0	m '	ب	1				16 yr	
P.O. Box 6	The law requires that the death certific ste hes been signed by the attending p page 2 should be detached for use es:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pro					23	d. Dale of de Month	livery Day Ye	ar
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions of	ontribuling to death be	ut not resulting		iderlying ca	_				pacco use		o the cause of dea	
al Reco	n: The law requicete hes been r. page 2 shoul	Completed	TYPIT	0.=>-	, >						24a. Was a autops perform	y ned?	24b. Were a prior to death?	ulopsy findings av completion of cau s 2 No	ailable ise ol
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 Ho 27. Manner of Death 1 Matural 5 Pending investigation	Hospital: 1 Inpalie 28a. Date of Injur (Month, Da)		Outpatien Time of Injury	-	A Other	. 4 Nurs	sing Home	Check only on 5 Preside d. Describe ho	nce 6		ecify)	
Divis	tal or Attandi s after death al Dirsctor: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ary - Al home, c. (Specify)	larm, sire	eet, factory	, office		28	I. Location (St City or Town		Number or R	ural Route Numbe	97,
	To the Hospital or within 24 hours after To the Funeral Dir. 7completely filled in	edical	29a. Certifier (Check only one) 1 ▶ Certifying Ph 2 ■ Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination a	lge, death and/or inv	occurred a estigation,	at the time in my opi	a, date and nion, death	place, an occurred	d due to the call at the time, d	ause(s) ar ate and p	nd manner a lace, and du	s stated. e to the cause(s)	
)	To To Toom	Σ	29b. Signature and title of certifier	-			1	. License		7				th, Day, Year)	
1	11/60	•	30. Name and address of person who o	ompleted cause of do	eath (Item 23a	a) (Type, I	Print)	aa,	5 0 7	73	~	~/ \ \	1	A 30 T	c
0	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1	call !	~\^	-W	1/7		1133	~~		<i>av /</i>

DHMH 17 Rev 1/2001

L. paolone

			1 - For State of Mar	yland / I	Department of Certificate				ne 0 0 7	11540
	Physicia	210	1. Decedent's Name (First, Middle, Last)					ate of Death	Day Yes	3. Time of Death
	Physicia /Medic		RUSSELL DANIEL ROBINSON					irch,	21 2a	y 0225 M
	Examin	er	4a. Facility Name (If not institution, give street and number) MEMOVI (1) HOS DITCU at Ea	Ho	46. City, 10	wn, or Location	n of Death		4c. County of D	eath
15	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last bi	irthday) If Under 1		er 24 Hrs. 8. D Min. (A	ate of Birth		Birthplace (State or Foreign Country)
de .	Director			87	Yrs. Months (Days Hours	NO	ate of Birth fonth, Day, Y 7. 20 1	019 0	HIO
	and bw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Location					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow	to	MD TALBOT		EASTON					1X Yes 2 ☐ No
	th the or 28s	Director	10e. Street and Number		10f. Zip C			10g	j. Citizen of What	
0)	ath w	ral	501 DUTCHMANS LANE				601		US	
0	itemi	une	11. Marital Status 12. Was Decedent Ev Amed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No		13. Was Deceder If Yes, specify	rt of Hispanic C Cuban, Mexic	an, Puerto Ricar	res or No- i, etc.)	Black, W	merican Indian, /hite, etc.
30 G	urs al	by	1 ☐ Never Married 2 ☐ Married 1 🕱 Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 €	No Specif	y:		Specify: W	HITE
, HUS,	72 ho natur	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed)	16a	a. Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during me	ost of working	16	b. Kind of Busine	ess/Industry
7- 5	within ane. than	idmi	Elementary/Secondary (0-12) College (1-4or 5+)	SUPERVISO			CI	TEMT CAT	MANUFACTURING
_	filed Hygid other	Be Co	17. Father's Name (First, Middle, Last)		DOLEKATO		her's Name (Firs			IMIOTACIOKING
an C	uld be Mental Irked c	To B	DANIEL W. ROBINSON			H	AZEL ATI	KIN		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ehow any Injury or other traumatic avant, the Medical Evant is at must be notified at once.	Se S	19a. Informant's Name/Relationship (Type, Print) MARTHA R. MOSES/DAUGHTER		b. Mailing Address (S 21710 COV				-	
-	1 and Health em 27		MARTHA R. MUSES/DAUGHTER 20a. Method of Disposition	20b. Place of	of Disposition (Name	of	Date		c. Location - City	
₩ Ē	ages ant of it: If It y or o		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemete	ery, crematory`or other PEAKE CRE	er place)	CTR 3/22			SVILLE, MD
HODE Baltimore	mit. F partme portan / Injur		21. Signature of Funeral Service Licensee	•						L HOME PA
, m	Depa Impo any l		Joseph M. Ostranski, Cf	7.5Q					D 21601	n norm ix
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	ne death. Do	not enter the mode	of dying, such a	as cardiac or res	piratory arrest	t,	Approximate interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	tion	preun	20019				Days
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6876	5 × 6	dicai	d				<u> </u>			
ox (nding use a	υ/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of						23d. Date of	delivery
œ.	death	sicia	in the past 12 months? 1 Yes 2 No		h 3 □Ectopic pred 5 □ Other (spec				Month	Day Year
P.O.	es that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	9 ☐ Unknown Part II. Other significant conditions contributing to death but	ant cognition	in the underlying on	eno enuos in Dor	+1	23a Did toba	cco use contribut	e to the cause of death?
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifica death. death. sctor: After this certificate has been signed by the attending ph the funeral director, page 2 should be detached for use as th	d by	0	lee	in the directlying cac	iso given in rai				Probably 4 Moknown
Š	w requir	Completed						24a. Was an	24b. Were	autopsy findings available
Re	The lav	E O						autopsy performe I ☐ Yes 2	ed? deat	
ita	ding Physician: The n. n. After this certilicate his funeral director, page	BeC	25. Was case referred to medical examiner?			*	ce of Death Ch			
of V	Physic this co		1 Yes 2 60 Hospital: 1 Inpatient		Outpatient 3 DOA				ce 6 Other (5	Specify)
uo uo	ding F h. After funera	tion	27. Manner of Death 1 ② Natural 5 □ Pending (Month, Day) 2 □ Accident investigation	Year)	Time of 280	Unjury at Work? 1 ☐ Yes 2[Describe now	r injury occurred	
Visi	Attendiur death.	ifica	3 Suicide 6 Could not be determined 28e. Place of Injur	y - At home, f	farm, street, factory,		28f. L			r Rural Route Number,
á	tal or rs afte al Dir	Certification; To	4 ☐ Homicide distantined building, etc.	(Specify)				City or Town, .	Siate)	
	To the Hospital or Attendi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	edicai	29a. Certifier 1 Socertifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of and manner state	examination a						
	To t with To t	Σ	29b. Signature and title of certifier	0	VD 29c.	License numbe	771,0		1. Date signed (M	
			Playsim varymath	m		05	1141	17	HRCH Z	21 2007
4	OTIVA		30. Name and address of person who completed cause of dea LAKSHMI VAIDYANATHAN M.D.			ON ST.	EASTON	, MD 2	1601	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar			,				
	Registr	ar	MAR 2 2 2007	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month (13 2000 ROS 185 **Physician** CYNTHA /Medical County of Death
MONTGOMER 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner MONTGOMPRY GENERAL HOSPITAL OLNA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F New York 72 Director 160-28-1733 March 19, 1935 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2本 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number II.S.A. 20904 12501 Eastbourne Drive Funeral 14 Bace - American Indian. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. hours after 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: þ Caucasian 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 should be filed w π and Mental Hygier 1s marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; If item 27 Is marked any Injury or other traumatic ew. Dorothy Lyndall Fox LeRoy Siggins Gibson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3041 Green Valley Road, Ijamsville, Maryland 21754 Tevi Grimm - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Scandia Cemetery 3/30/2007 Elk Township, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BUREDING **Physician** /Medical Due to (or as a consequence of): **Examiner** PTURED APPRIC ANEURSUA Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed HYPORTONSION and burial-trai Due to (or as a consequence of) Box 68760 attending physician pe Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Yea in the past 12 months? 1 ☐ Yes 2 🖪 No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. SCYPRE CHRONIC OBSTRUCTIVE PULMONHA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performe certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Jopatient 2 ER/Outpatient 3 DOA ျှ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No e Hospital or Attendi 24 hours after death. e Funeral Director: A letely filled in by the fu death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 1 and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 22,2007 136252 M

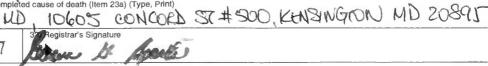
State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who comple

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7, KARIYA.



eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/Amend#10f.PerFHPGC3-28-07cr Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 23 **Physician** 2007 8:05AM MARCH ROBINSON EDITH Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL LINTON If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, AUGUST 1 M 2 XF VIRGINIA 8,1938 68 229-50-0623 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1√2 Yes 2 □ No Director MD PRINCE GEORGES UPPER MARLBORO 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20772 U.S.A. 9702 MUIRFIELD DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married BLACK 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any Injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED COSMETOLOGIST 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAVID KEATTS ETHEL ANDERSON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20744 HIGHLAND VIEW FT. WASHINGTON, MD SABRENA HARDIE/DAUGHTER 10012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/30/07 BRENTWOOD, MD FT.LINCOLN CEM. 4 Donation 5 Other (Specify) 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 21. Signature of Funeral Service Licensee 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 TENDULO D 23a. Part1. Enter th La ease, o shock, or heart failure. List pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) un Kro -/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autonsy performed Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident hours after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide 24 hours a 1 - eritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 30. Name and address of ers eted cause of death (Item 23a) (Type, Print) 0

State Registrar Registrar's Signature

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 3 Day Year **Physician** CHARLES REID 0904AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENUDST HUSPITAL TAKONUT PARK MON TOOMER If Under 1 Year If Under 24 Hrs. 8.
Months Days Hours Min. 3. Date of Birth (Month, Day, Year), 12/14/1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 72 Washington, DC 577-44-5487 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location woye 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or items 23s or 28s-f show any injury or other treumatic event, in a Medical Examinar must be notified at once. DC Washington, DC Be Completed by Funeral Director Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20009 USA 20001 15th St. NW #812 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 K Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles A. Reid Battle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1110 16th St. NE, Washington, DC 20002 Barnes / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Vashington National Cem.3/29/2007 Suitland, Maryland 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Lig 716 Kennedy St. NW, Washington, DC 23a. Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a ATHEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of) Examiner Sequer titility list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ul or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the ettending physicien and in by the tuneral director, page 2 should be detached for use as the burial-transit in by the tuneral director, Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No. 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2. ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1/7 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the ş 29b. Signature and title of continer 60319 03,192007 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave., Takoma Park, MD 20912 HAMMEN DARCIE 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MAR 2 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** EDNA MARIE 2:30 03 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SURERSVILLE 5504 SUDLERSVILLE GUEN ANNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/30/1955 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🗓 F 217-68-1562 51 Director MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked othsr then "natural", or items 23s or 28s-f show other traumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits MDQUEEN ANNE'S SUDLERSVILLE 1 ☐ Yes 2¶ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 5504 SUDLERSVILLE ROAD 21668 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced Year or Dates: natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CASPER HENDRICKS EDNA WAHLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RALPH REA SR./HUSBAND 5504 SUDLERSVILLE ROAD, SUDLERSVILLE, MD 21668 20b. Place of Disposition (Name of 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If iter
any injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 03/31/2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA 130 SPEER ROAD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy be detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. the the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificete 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ٩ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification; 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funarsi Dirs 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21313 of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month

Vashington

32. Registrar's Signature

2007

, Chestertown, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
APR 1 1 2007

32. Registrar's Signature

			For State Registrer	State of Ma	aryland	•	irtmen <i>tificat</i> e					giene Reg. No.	00	-	1545
	Physici /Medi		Decedent's Name (First, Middle, La NORMA W. SOMERS								2. Date of De Month Marc	Day	2	rear 007	3. Time of Death 11:40 PM
	Examir		4a. Facility Name (If not institution, gir				4b. City,		Location			4c. (County of		
	Funeral Director			Sex 7. Age	ne Pi e (In yrs. Ias 85		If Under Months		asto If Under Hours		8. Date of Bird (Month, Da JUNE 3	th V. Year)		1 bot 9. Birthpla Count MARY	ace (State or Foreign
	P.		Usual Residence of Decedent										1		
	arylar	_	10a. State 10b. County		10c. City, 7			·n						10	d. Inside City Limits
	Ne M	Director	MD TALBOT	<u> </u>		N.	EWCOM					40 000	4.00		1 ☐ Yes 2 No
	with a or 3		10e. Street and Number	200			10f. Zip		6 E 2			10g. Citiz			ry r
	death with the Maryland me 23a or 28a-f ehow must be notified at	Funerai	7383 BACK STREE	12. Was Decedent E	Ever in U.S.	13. V	Vas Deced		653 spanic Or	igin? (Spec	rfy Yes or No ican, etc.)	- 1	USA 4. Race	- America	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. It Health and Sa or 28a-1 ehow tem 27 is marked other than "natural", or itame 23a or 28a-1 ehow other traumatic event, the Modical Examinar most be notified.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 N If Yes, Give Year or Dates:	lo		Yes, spec		Specify.		ican, etc.)	1	Black, Specify:	White, e	
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Somers Maryland	2 should be fi and Mental H ie marked of aumatic ever	To Be	JOHN KREMEYER	0							(First, Middle, HAWNER	walden ;	sumame,	,	
Somer	shoul nd Me marl	Ĕ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a			Route Numbe	er, City or	Town, Si	tate, Zip	Code)
_	and 2 alth a 127 is		THOMAS E. SOMERS	S/SON		PO 1	BOX 3	54 R	OYAL	OAK,	MARYL	AND 2	21662	2	
ma	of He of He		20a. Method of Disposition 1 XBurial 2 Cremation 3 [Domewal from State	20b. Plac	e of Dispos	sition (Nan	ie of	T	Da			cation - C		vn, State
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Norma Baltimore,	permit. Pages 1 and 2.4 Depertment of Health ar Important: If Item 27 ie any injury or other trau once.		21. Signature of Funeral Service Lice	· MER	ERO	$\bigcirc \overset{22}{F}$	Name and ELLOW S.	Address S H HAR	s of Facili ELFE RISO	NBEIN N ST	& NEW	NAM I	UNE:	RAL E	IOME PA
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	/Medical		disease or condition resulting in death)	a. Due to (or as a	a consequer	YLMS nce of):	1	KAIL							mound
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o လ	aw requir s been si 2 should i	Completed									24a. Was		24b. We	ere autop	sy findings available
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Division of Vital Records,	To the Hospitel or Attending Physicien: The law requires that the death certi within 24 hours after death. To the Funerel Director: After this certificate hes been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Certification;	2 Accident investigation 3 Suicide 6 Could not to determined	De 00 51 41	iry - At home (Specify)	e, farm, stre	M eet, factory		′es 2 □		Bf. Location (S City or Tox			or Rural	Route Number,
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	3-		30. Name and address of person who	1,000	eath (Item 2:		Print)	NS.	LAN	£	EAST		MA		1601
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 7 2007	32. Registra			<u> </u>								

Registrar

		1	1- For State of Maryland / Department of Certificate of Registrar		l Hygiene	UU I II UTI	
	Physicia /Medic Examin	in al	1. Decedent's Name (First, Middle, Last) Robert Lee Smith 4a. Facility Name (If not institution, give street and number) 4b. City, Town	2. Date Mor 3	2	Year 11564M	
	Funeral Director		Holly Center 5. Social Security Number 220-72-2119 6. Sex 192M 20 F 7. Age (In yrs. last birthday) Wonths Day	ar If Under 24 Hrs. 8. Date	e of Birth nth, Day, Year)		
	ours after death with the Maryland elf. or Items 23e or 28e-f show Exertiner must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Mul Wicomico Salisbury 10e, Street and Number 10f. Zip Code 9 2 1 Show Hill Rd. 2186	, MD		10d. Inside City Limits 12 Yes 2 □ No tizen of What Country?	
9800	ours after el', or ite Exemine	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of the Yes, specify Circles and the Yes, specify Circles and Tolerand of the Yes and Tole			14. Race - American Indian, Black, White, etc. Specify: Black	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2007 MARCH 16 07:24AMM LACEY ALBERT SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **EASTON** 706 DOVER ROAD If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year)

DEC 11 1993 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F MARYLAND 13 Yrs Director 212-41-8327 Usual Residence of Decedent with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai', or iteme 23a or 28a-f ehow Examiner must be molified at 1 X Yes 2 ☐ No **EASTON** Directo TALBOT MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21601 706 DOVER ROAD Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Int: if Item 27 is marked other then "natural", or Iteme 23. 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced WHITE er then "natura t, the Madical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) **ELEMENTARY SCHOOL** STUDENT KINDERGARTEN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JONATHAN DAVID SMITH, SR. KATHY WRIGHT 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) 706 DOVER ROAD, EASTON, MARYLAND 21601 KATHY MARIE SMITH/MOTHER 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages of Department of Himportant: if Ite ony injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/21/2007 TRAPPE, MARYLAND LANDING NECK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA C.FSP. Toseph Ustrowski 31 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final ENCRPHALOPATITY ROGRESSIVE Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No မ After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Certification; 27. Manner of Death 5 Pending 1 Natural 2 ☐ Accident n 24 hours after death.

The Funeral Director: All pletely filled in by the fur 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge death occurred at the time data and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2st Certifier Medical To the within 2 29c. License number 29b. Signature and title of certified D23032

Registrar

DHMH 17 Rev 1/2001

30. Name and address

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year P M **Physician** 6:39 24, 2007 Stark Geneva Adams March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Suppose 7, 9. Birthplace (State or Foreign Country) Georgia 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 2 F June 88 252-24-3723 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1X Yes 2 □ No Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20814 5909 Rossmore Dr. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 þ White 3 Nidowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Lou Long Charles King Adams ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter Frederick, Maryland 21703 6804 Wythe Court Elizabeth Stark Kline/ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Oddfellows Cemetery March 31,07 Starkville, MS. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INc. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 5130 Wisconsin Ave. N.W. Wash. D.C. 20016 Immediate Cause (Final disease or condition resulting in death) CALDFORLLMONARY **Physician** /Medical Due to (or as a consequence of): Examiner MULTE SYSTIM if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PSEUDUMOWAZ The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IE FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 □ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leo C. Rotello, M.D.

00052774

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registre Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 10:00 PM March 25, 2007 Dorothy F. Shapiro /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🕱 F Yrs. 85 July 23, 1921 098-12-4228 New York Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f ehow the Medical Examiner must be notified at 1 ☐Yes 2 No Directo Maryland Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number "natural", or Iteme 23a 20895 U.S.A. 3221 University Blvd., West permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if Item 27 le marked other than "natural", or Iteme 23a any Injury or other traumatic event, the Madical Examinations. Apt. 11 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 2 Caucasian 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) County Government 12 Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Isidore Frankel Jennie Wilner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2800 Southern Avenue, Baltimore, Maryland 21214 Daniel I. Shapiro - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
Parklawn Memorial Park & 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/29/2007 Rockville, Maryland Menorah Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician Decompensated Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Cardiomyopathy with EF = 20% if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-translt or Attending Physician: The law requires that the death certificate be executed Malnutrition Due to (or as a consequence of) Box 68760 Physician/Medical Myocardial Infarction IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 🗌 Unknown à Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cate has been significant page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has performed' 1 Yes 2 No After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☑ No 1 x Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of fnjury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BK 975 8876 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rama Kapoor, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

David	Michael	Sloley

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	State of Maryland /	Department of He	ealth and Men	tal Hygiene

Physicis		State of Maryland / Department of For State Certificate of Certifi	of Death	Reg. No. of Death 3. Time of Death
Physicia al Examir	ner	DAVID MICHAEL SLOLEY JR	Mont Marc	h 22, 2007 Year 0303 hrs
		4a. Facility Name (if not institution, give street and number) 4800 Block of Allentown Road	4b. City, Town, or Location of Death Temple Hills	4c. County of Death Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 577-11-4646 1 Mg 2 F 24	Marchael Day of Harris I Min	e of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign WASHIN 2^{Country} TON, D
, any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation	10d Inside City Limits
Maryland 28a-f show i at once.	Director	MD PRINCE GEORGES CAPITO 10e. Street and Number	L HEIGHTS 10f. Zip Code	1 X Yes 2 No
th the M 23a or 2 notified		503-67TH. PLACE	20743	U.S.A.
be filed within 72 hours after death with the Maryland ntal Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Fune	1 X Never Married 2 Married Armed Forces? If	/as Decedent of Hispanic Origin? (Specify Ye Yes, specify Cuban, Mexican, Puerto Rican, e	
ld be filed within 72 hours afte dental Hygiene narked other than "natural", event, the Medical Examiner	eted by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of work don- most of working life. DO NOT use retired)	e 16b. Kind of Business/Industry
ed within 72 Iygiene other than he Medical	Completed	17. Father's Name (First, Middle, Last)	TRACTOR 18. Mother's Name (First, M	COMCAST CABLE diddle, Maiden Surname)
e 2 2 d	a	DAVID M. SLOLEY SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ELAINE D	
ages I and 2 shou nt of Health and N nt: If item 27 is n other traumatic		20a. Method of Disposition 20b. Place of Dispo	osition (Name of cemetery, Date	OL HEIGHTS, MD 20743 20c. Location - City or Town, State
Pages 1 ment of F tant: If i or other		1 XXBurial 2 Cremation 3 Removal from State crematory or of 4 Donation 5 Other Specify: FT.LINC	OLN CEM 4/3/0	
permit. Page Department of Important: injury or oth	\Box	X PMIAX L OTIWATE	6500 ALLENTOWN RD	KLAND FUNERAL SERVIC . CAMP SPRINGS, MD 2
ysician Medical caminer	4 4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Gunshot Wounds	the mode of dying, such as cardiac or respira	Approximate Interval Between Onset and Death
Kammer		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		
cuted and transit	al Exa	events resulting in death) Last Due to (or as a consequence of): d.		
te be executed nysician and burial - transit	ledical	UNPENDED AMENDED		23d. Date of delivery
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/N	past 12 months?	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
that the de ted by the detached f	by Phys	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23	e. Did tobacco use contribute to the cause of death? Yes 2 V No 3 Probably 4 Unknown
law requires that has been signed to 2 should be deta	Completed			a Was an autopsy findings available performed?
certificate		25. Was case referred to medical	26 Place of Death (Check only one	✓ Yes 2 No 1 ✓ Yes 2 No
ysician: this certifi director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		
tal or Attending Physician: The law requir rs after death. ral Director: After this certificate has been s led in by the funeral director, page 2 should!	tion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Mar 22, 2007 28b. Time of 0300 hrs		escribe how injury occurred ct shot
pital or Attoours after de leral Director filled in by t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Major Road in Vehic	or	cation (Street and Number or Rural Route Number, Cit Town, State) Block of Allentown Road, Temple Hills, MD
To the Hospi within 24 hou To the Funer completely fil	Medical Co	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investign.	curred at the time, date and place, and due to gation, in my opinion, death occurred at the tin	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			1	1.4 1.00 0007
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	March 22, 2007

Registrar

			1 - For State Registrar	State of Ma		epartme Certifica			d Mental Hy	giene Reg. No.2		11552	
	Physic	ian	1. Decedent's Name (First, Middle, La	•					2. Date of De	. Day	Year	3. Time of Death	
	/Medi	cal	Diane Faye Slac						MARCH		CO7	0320 M	
	Exami	ner	4a. Facility Name (If not institution, gir DORCHESTER GEN		CAITHI			Location of D			4c. County of Death DORCHESTER		
	Funeral				(In yrs. last birth	day) If Un	der 1 Year	If Under 24 I	Irs. 8. Date of Bi	rth			
	Director		218-50-1741	1□M 2 2 /F	59 Y	rs. Month	is Oays	Hours A	Feb. 5	, 1948	Mar	place (State or Foreign ntry) 'y Land	
	pur A		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits	
	Maryli f eho	ō	Maryland Dorche	ston	-	ambrio	1~~					1 as 2 No	
	h the Marylan r 28a-f ehow	rect	10e. Street and Number	Stel			Zip Code			10g. Citizen of	What Cou	intry?	
	death with the Maryland me 23a or 28a-f ehow LTMI te notified at	Funeral Director	405 Phillips Aven	ue				21613			USA	1	
	- me	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13. Was De	cedent of Hi	spanic Origin?	(Specify Yes or Ne uerto Rican, etc.)	o- 14. Ra	ice - Ameri ack, White,	can Indian,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 1	6		2410		20110 1 110011, 2101,	Spec	ifv:		
ô	within 72 hours after ene. then "neturel", or ite	ed b	15. Decedent's E	Year or Dates:	16a F	Decedent's U	sual Occupa	ation		16b. Kind of		nite	
215	hin 72	Completed	(Specify only highest gr Elementary/Secondary (0-12)			Give kind of life. DO NO	work done o	luring most of	working	TOB. KING OF	203111033111	idustry	
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pu	tal Hydral Hydrau even	Be	17. Father's Name (First, Middle, Last						Name (First, Middle		me)		
3	and Mental Hygiene and Mental Hygiene is marked other the eumatic event, the incompanion in the incompanion	မှ	Woolford F. Sla						ouise Elz				
<u>⊠</u>	d 2 st th and t7 is r treun		19a. Informant's Name/Relationship William L. Smith						Rural Route Numb				
Baltimore, Maryland 21215-0036	is 1 and 2 should be filed of Health and Mental Hyg liem 27 is marked othe other treumatic event,		20a. Method of Disposition		20b. Place of D	Disposition (/	Vame of		, Cambrid	20c. Location			
E G	Page: nt: ff ry or		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	□Removal from State	1	crematory c erans			/30/2007	Hurloc	k. MD)	
alti	permit. Pages 'Department of H Important: if Ite any injury or ot		Signature of Funeral Septice Lice	nsee									
-	89 5 9	1	23a Part1. Enter the disease, or con shock, or heart failure. List only	ex-con	well	308 F	ligh S	t., Car	Funeral H mbridge,	MD 2161	а. 3		
8760,	Physician Medical Examiner Medical Examiner Physician and physician and the priral-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	consequence of):	Herri	aces	eer				
P.O. Box 68	the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 19 Unknown	2 ☐ Fetal death	3 ⊟Ectopic 5 ⊡ Other					ate of deliver	ery Day Year	
	w requires that s been signed t should be deta	Completed by P	Part II. Other significant conditions	contributing to death bu	t not resulting in t	he underlyin	g cause give	n in Part I.		obacco use cor		he cause of death?	
00	s beer shou	lete						-	24a. Was	an 24b.	Were auto	ppsy findings available	
Re	The lav	mo								psy ormed?	prior to co death?	mpletion of cause of	
ta	siclan: Th certificate rector, pag	Be C	25. Was case referred to medical					26. Place of I	1 ☐ Yes Death (Check only o	2 No	1 U Yes	28-10	
<u>></u>	Physiclan: this certific ral director,	다 교	examiner? 1 Yes 2 No	Hospital: 1 Thipatier	nt 2 ER/Outp	atient 3	DOA Othe	r: 4 🗆 Nursin	g Home 5 ☐ Resi	dence 6 □Ot	her (Specif	(y)	
n o	ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injun (Month, Day	Year) 28b. Tin Inju	шгу	28c. Injury Work	at ?		how injury occu			
Division of Vital Records,	l or Attend after death Director: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e One Diese of Leise	ry - At home, farm . (Specify)	M n, street, fact		es 2⊡No	28f. Location (City or To	Street and Num wn, State)	ber or Rura	al Route Number,	
	To the Hospital or Attending Phys within 24 hours atter death. To the Funeral Director: After this completaly filled in by the funeral di	edical C	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exam	nysician: To the best o miner: On the basis of and manner stat	examination and/	death occurre or investigati	ed at the tim on, in my op	e, date and pli inion, death o	ace, and due to the courred at the time,	cause(s) and m	anner as s , and due to	tated. o the cause(s)	
	To the To the Comp.	ž	29b. Signature and title of certifier	140		2	29c. License			29d. Date sign			
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			30. Name and address of person who			,, ,		40 4			_		
67	Sta	ite.	NOMAN THANK 31. Date filed (Month, Day, Year)	32. Registra	パタルル r's Signature	3/	CAM	BRIDG	E 790	2/0	13		
	Registi		MAR 2 9	32. Regista 2007	and M	Soo	160						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 18, 2007 7:45 PM MORGAN SARGENT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1**X** M 2□ F 002-12-5945 80 Jan. 2, 1927 New Hampshire Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes X☐ No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21703 United States 5730 Magnolia Tree Court, A-11 Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2∏ No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Government lith and Mental Hygier 27 Is marked other the r traumatic event, the <u>Physicist</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Morgan Phillip Sargent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health ar
Important: If Item 27 Is any Injury or other free: 5730 Magnolia Tree Crt. A-11, Frederick, MD 21703 Shirley Sargent / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition T∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Garden 3/21/2007 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 YRS Physician FIBROSIS PUL MONAR /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury Due to (or as a consequence of): Examine be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 4 Pregnent at time of death 1 ☐ Yes 2 ☐ No P.0. ed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1□ Yes 2 1100 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a Date of Injury 28c. Injury at Work? 27. Manner of Death Hospital or Attending (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined filled in by 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the within To the

State Registrar

THOMAS VOHNSON DR, FREDERICE, 21702 65C MA A. DONELSON

ne lum

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 2 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

32. Føgistrar's Signature

29c. License number

DZ1936

29d. Date signed (Month, Day, Year)

03/20/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #PI, 25,27,28a-f, per/ME,886, 2/25/08 TT

Amend 28d, per/ME,687/, 3/3/08 TT

Por State Registrar Amend Line 31 per Health Dept KG Certificate of Death

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year WILLIAM EDGAR SMITH, III MARCH 2007 6:58 18, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL MEDICAL CENTER <u>ANNAPOLIS</u> ANNE ARUNDEL If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) JANUARY 31, 1967 Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 X M 2 ☐ F 40 Director 213-80-0462 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the flat and Mental Hygiene. and the flat and 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Directo MARYLAND | QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 CHESAPEAKE DRIVE 21666 **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DRAFTSMAN COMPUTER DESIGN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM EDGAR SMITH, JR PATRICIA ANN TYSON ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2316 WEST SEA PALM COURT, SUPPLY, NORTH CAROLINA 28462 WILLIAM EDGAR SMITH, JR/FATHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MARCH 23. 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY 2007 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CLUADEIPLEGIA Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed VEHICLE MUTUR ENFORTON APPROVED BY MEDICAL EXAMPLER physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by 1 🗌 Yes 210 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2 No Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner?
1 1 Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ OA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To Division or 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d Describe how injury occurred **subject passenger driver** in a car 5 ☐ Pending investigation Injury unk^{1 □ Yes} 2 □ No 1992 unk 2 X Accident collided with another vehicle 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide roadway within 24 hours a To the Funeral I 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ブヘ 30. Name and ad person who completed cause of death (Item 23a) (Type, Print) 277 Peninsula Farm Rd MO 21012 gistrar's Signature Date file State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MRCK 1505 2007 /Medical igility Name (If not institution, give street and number City, Town, or Location of Death County of Death Examiner Chestertowk

If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days QUEEN Anne, MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28a-f show the Madical Examiner must be notified at Be Completed by Funeral Director ent 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: f Yes, Give Year or Dates: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADORER or other traumatic event, Department of Health and Mental Hy importent: if Item 27 is marked othery injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other) Method of Disposition 3 Removal from State Burial 2 Cremation 4 Donation 5 Other (Specify)

21. Sonature 1 Full eral Service Licensee 22. Name and Address of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMON HA Physician /Medical ZHEIMERS DEMENTIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical sete has been signed by the attending phys page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ADVANCED 2 No 3 Probably 1 ☐ Yes 4 | Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes ours after death.
neral Director: After this certifice
filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) H0062423 f person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 6602 Chuech Hill Rd dela 32. Registar's Signature 31. Date filed (Month, Day, Year) State MAR 3 0 Registrar 2007

		For State Registrar	State of Maryland		irtment of H			jiene2 () eg. No.	07	11556
		1. Decedent's Name (First, Middle, Las	1)			,	2. Date of Dea	th		3. Time of Death
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Exami		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	1	4c. County	of Death	
		21510 York Road	Ē	_	Maryla	nd Line		Balti	imore	=
Funeral		5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthpla	ace (State or Foreign
Director		712-74. 1d	68	Yrs.			11/3	138		
and w		Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	cation				10	d. Inside City Limits
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death with the Maryland ms 23a or 28a-f ahow	Funeral Director	21510 York Roa	12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of H f Yes, specify Cuba		pecify Yes or No-	14. Race	- America	
r iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☑Yes 2 ☐ No				o Rican, etc.)		k, White, e	tc.
in i	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 1962 Year or Dates: 1968	-	I∐Yes 2½∏No	Specify:		Specify	Wł	nite
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ylcould loould l Men narke	2	William R. Sty		401 11 11			E Bachr		O4-1- 78* . /	2. 4.1
Mar 12 sh 12 sh 13 m		19a. Informant's Name/Relationship (į.	g Address (Street					
DESILITIOFE, INSTYIETTO Z IZ IS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinational be notified at once.		Susan Stygler/V	20b. Pl	ace of Dispo	O York 1 sition (Name of			20c. Location -		
In its		1 Burial 2 ☐ Cremation 3 ☐	Removal from State MC	thodi	natory or other plac	(0)			e some	
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Department of the popular in popu		21. Signature of Funeral Service Licen	Noto stol	4 4 7						
		23a. Part1. Enter the disease, or com	plications that caused the death			d St.,				L / 349 Approximate
		shock, or heart failure. List only	one cause on each line.					031,		Interval Between Onset and Death
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andin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal		Ectopic pregnancy			23d. Date	e of deliver	у
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To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		9d. Date signed	(Month D	Dav. Year)
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10		30. Name and address of person who	completed cause of death (Item	CHADI	ES ST. FFLIC	702, BA	TIMADE	MARIL	ALIA	21204
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	W VI. T	NG OF	LITTIONE,	Image	MNU	-1-01
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** March 22, 2007 6:00 p Donald C. Tieff /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Potomac Valley Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11☑ M 2 □ F 25, 1942 New Jersey Director 140-34-8107 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐Yes 2 X No Maryland | Montgomery Germantown Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20874 United States 12610 Grey Eagle Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married Married 2**X** No 1 ☐ Yes 2 ▼ No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive Service Sta. <u>Manager</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Oliver Tieff Frances Huff ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12610 Grey Eagle Court, Germantown, MD 20874 Kadi Tieff - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Fort Lincoln Cremat.3/28/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signator of Furieral Service 22. Name and Address of Facility Simple Tribute, 1040 Rockville Pike, Rockville, MD 20852 en Alp 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** vee disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entail Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed burial-trar Due to (or as a consequence of): P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate be Completed by Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, 1 Tes 2 No 3 Probably 4 Munknown 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death seral Director: / filled in by the f 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I

State

Registrar DHMH 17 Rev 1/2001 29a. Certifier

29b. Signature

(Check only one)

31. Date filed (Month,

and title of certifier

mend

Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

Medical

2401

gistrar's Signature

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Research Blub

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #1 per PHYS/FH 03-23-2000 ficate of Death CNM 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Lenora A. Twenty March 18, 2007 4:32 A. Leonora A. Twenty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Williamsport Williamsport Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Hours Min. Days Year 1 M 2 CX 93 Director 214-10-2681 Yrs. March 26, 1913 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be nutitied at Washington Maryland Williamsport 1 ☐ Yes 2 ▼ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 16505 Virginia Avenue 238 21795 USA or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. White δ 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria worker education or other traumatic event, permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy.
Important: If item 27 is marked otherny injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adolphus Fox Lilly Crum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Himes - grandson 87 Evening Star Lane, Martinsburg West Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Departure 1 Cremation 3 Removal from State 4 Donatton 5 Other (Specify) Mt. Olivet Cemetery 3-22-2007 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Finat disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit To the Hospital or Attending Phyaician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 ☐ Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ (RMCCATTIN 1 ☐ Yes 2 👿 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA his After this 27. Mannef of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Alatural death. 1 ☐ Yes 2 ☐ No hours after death funeral Director: / 2 Accident the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours and To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Deficiency Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Mostin, Day, Year) 29b. Signatur (and ut 29c. License numbe)((6A Cattra TEPAL 31. Date filed (Month, Day, State Registrar

07-02302 David Edward Tu		Otate of Maryland / Doparation of Fredam and Metho			7 1155
Physicia		- For State Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De	Reg. No.	3. Time of Death
Physicia <u>Me</u> dical Examir		DAVID EDWARD TURNER	Month March 2	5, 2007 Year	1430 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Description of D	Death	4c. County of Dea	ath
		7018 Ocean Gateway Easton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	24Hrs 8 Date of	Talbot Birth(MM/DD/YYYY) 9. I	Birthplace (State or
Funeral Director	- 1	Months Days Hours	Min	For	eign Country MARYLAND
	ŀ	220-66-4344 1 A M 2 F 33 Yrs.	PARCI	29, 1933	MARILAND
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No
daryland 28a-f show 1 at once.	į	MARYLAND QUEEN ANNE S CENTREVILLE 10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene of: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director				Santy :
with th	計	307 SOUTH LIBERTY STREET 21617 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin			erican Indian, Black,
r death wi or items? must be	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, P	uerto Rican, etc.)	White, etc.	
after	J.	3 Widowed 4 Divorced if Yes, Give Year or Dates:		Specify: WI	HITE
2 hours after "natural", f Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kin during most of working life. DO NOT us			
0036 within 72 iene er than Medical	Completed	4+ SOCIAL WORKER		STATE OF	MARYLAND
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 nt of Health and Mental Hygiene nt: If item 27 is marked other than "other traumatic event, the Medical		17. Father's Name (First, Middle, Last) 18.Mother's	Name (First, Middle	e, Maiden Surname)	
2121: uld be fi Mental B marked c event,	o Be	EDWARD TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 19b. Mailing Address)	A MARJOR		ate Zin Code)
ID 2 : shoul and N 7 is m	\vdash	PATRICK THOMPSON/PERSONAL REPRESENTATIVE 102 EAST MAIN STRE			
e, M I and 2 Health item 2	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
more, Pages 1 an nent of He ant: If ite		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: CHESTERFIELD CEMETERY	MARCH 31, 2007		LE, MARYLAND
Baltimore, MD 21215-C permit Pages 1 and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the 1	İ	21. Samular of Pineral Service Lig. ns. 22. Name and Address of Facility FELLOWS, HELFENB			
Physician	4	23a. Part I. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each time.	Y STREET	- CENTREVIL	LE MD 21617 Approximate Interval Between Onset and
/Medical Examiner	ı	Immediate Cause (Final disease a Atherosclerotic cardiovascular disease			Death
		or condition resulting in death) Due to (or as a consequence of): b.			
	힐	if any, leading to immediate Due to (or as a consequence of):			
	xamine	Collegese or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
uted nd ransit	ΨÌ	d			
e exection articles are reconstructions are	dig	X UNPENDED AMENDED #23a,PII,27,perME, g866, 4/17/07 TI			
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execute. After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - tran		IF FEMALE: 23c. If yes, outcome of pregnancy	pregnancy	23d. Date of deliv Month	ery Day Year
x 68 n certif	ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	regriandy		
Boy e death the att	Physi	1 Yes 2 No 9 Unknown 9 Unknown		d tobacco use contribute	to the equipe of death?
that th	집	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Cocaine use		Yes 2 No 3 P	
IS, P. quires then signe and be do	ted	ocalie use	24a. W.	as an 24b. Were	autopsy findings available
COFC law re has be	ompleted		pe pe	rformed? death	
Re(The ficate	2	25. Was case referred to medical 26 Place of Death (C	1 Ye	s 2 No 1	Yes 2 No
/ital	o Be	examiner? [Hospital: 1 Innation: 2 FR/Outpatient 3 DOA Other		Residence 6 🗸 Ot	her: Scene
Division of Vital Records, tat or Attending Physician: The law requirers after death. In Director: After this certificate has been is led in by the funeral director, page 2 should I	\vdash 1	27. Manner of Death Yes 2 No 28a. Date of Injury (Month, Day, Year) Work?	28d. Descri	be how injury occurred	
ion fendin eath. or: A	흲	1 Natural 5 Pending 1 Yes 2 Natural 2 Accident Investigation			
Visi or Att or Att or Att in by	iii	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		n (Street and Number or n, State)	Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	4 Homicide (Specify) 29a. Certifier A Cartifier Bhyriains. To the best of my knowledge, death occurred at the time, date and place.		auro(a) and manner	tated
he Ho in 24 t he Fu pletely		(Check only one) New Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation, in my opinion, death occurred to the basis of examination and/or investigation.	e, and due to the c urred at the time, da	ause(s) and manner as s ate and place, and due to	the cause(s)
To t with To t	Medical	and manner stated. 29b. Signature and vittle of certifier 29c. License number		29d. Date signed (
	=	O.C.M.E.		March 26, 200	7
		30. Name and address of person who completed cause of death (Item 23a)			
		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 21201		

State 31. Date filed (Mo A A A), Year)?
Registrar DHMH 17 Rev 1/2001 OCME 2006

32. Weistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Line 31 per Health Dept KG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1330 M laryann nomar 3160 /Medical 4a. Facility Name (# not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 316 14 8612 Months 1 □ M 2 D F 83 Yrs Director 8/23/1923 INDIANA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10a, State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director MD QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 206 TENNESSEE ROAD 21666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any injury or other traumatte event. The Medical Examina-1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: WHITE ð **3**CWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER ? EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 McKEOWN ALVINA PILLMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 TENNESSEE ROAD STEVENSVILLE, MD 21666 ELISBETH P. WISLANDER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State STEVENSVILLE, MD CHESAPEAKE CREMATION CENTER 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License Name and Address of Facili FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD CHESTER, MD 21619 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or wons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) na /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit death certificate be executed Exami Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at Id be detached for 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2 No 1□ Yes Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA funeral 27. Mariner of Death 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Natural (Month, Day Year) 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in more death of the cause (s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Examiner The law requires that the death certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760, as attending | for use as

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Examiner

by Physician/Medical

Completed

Be

2

Certification:

Medical

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

be filed within 72 hours after ntal Hyoiene.

Is marked other

mportant: if item 27

Physician

/Medical

injury or other traumation

21215-0036

Baltimore,

THOMAS,

physician:

2

known

Name

the Hospitai within 24 hours a

25. Was case referred to medical examiner? 1 Yes 2X No 27. Manner of Death 1 🕅 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

D27578

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4/2/07

30. Name and address of person who completed cause of death (Item 20a) (Type, Print)

VA Maryland Health Care System Avelina Hernandez, M.D. Perry Point, MD 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Year **Physician** 10:16AM 2007 MAR /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) ocial Security Nu **Funeral** 1**⅓**M 2□ F 6/13/1962 Salvador none Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Prince George's Hyattsville 1 □Yes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5805 31st Avenue 20783 Salvador Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1X Yes 2□ No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced $\mathbf{E}\mathbf{I}$ Salvador 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Painter 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucia Villatoros Hector Bartolo Solano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5805 31st Avenue Hyattsville, Md 20783 Antonia Villatoros/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Nueva Granada, 1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State El Guayavo Cem. 4/02/2007 El Salvador PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 vease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final Neck disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Physician/Medical þ Completed

Physician /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

i and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. Heath and Mental Hygiene. Im 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

"natural", or items 23a or 28a-f show dical Examiner must be notified at

event, the Medical

Item 27

Department of h Important: If Ite any Injury or ot

use as the burial-transi and attending physician been signed by the sahould be detached page 2 funeral director, Certification: To Be this spital or Attendi nours after death. neral Director: A

resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 12
		24a. Was an autopsy performed? 1□ Yes 2 No 124b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2□ No 1□ Yes 2□ No
25. Was case referred to medical	26. Place of Death	Check onl one
examiner? 1 Yes 2	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only 2 Medical Example)	I ysician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or Investigation, in my opinion, death occurre	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

Ola-31. Date filed (Month, Day, 8

and manner stated.

nd address of person who completed cause of death (Item 23a) (Type, Print)

ST. BAHIMUIS MD 21201

within 24 hours a

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Vasquez 0520 Carmela 24,2007 March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🔀 F 91 216-02-4653 5/29/1915 Dominican Rep Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Montgomery Village MD Montgomery 1X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1011 A Little Ponds Place #6 20886 Dominican Republic 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 X Yes 2 □ No Specify: Black 3 XWidowed 4 ☐ Divorced Dominican Republic 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Valentin Mancebo</u> Cayetano Vasquez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13115 Dumbarton Drive Rockville, Md 20853 Ana M.Richardson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 3/28/2007 Gate of Heaven Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fungral Service PHILIPADES RINALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 9241 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting in death) des Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last atherosclerosi Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 💢 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

certificate be executed P.O. Box 68760 attending physician Récords, certificate 6r Vital the Hospital or Attending Physician: Division e Funeral

Physician

/Medical

Examiner

Funeral

Director

28a-f show ms 23a or 28a-f shov must be notified at

Items

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examiner once.

Physician

/Medical Examiner

Director

Funeral

þ

Completed

Be

Examiner

with the Maryland

Physician/Medical þ Completed Be Certification: To

25. Was case referred to medical examiner?

1 Natural 2 Accident 3 Suicide 4 Homicide

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a. Certifier

cal

29c. License number D56652

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Potter Matthew 31. Date filed (Month, Day, Year) MAR 2

1201 MD

and manner stated.

Seven Locks Road

State Registrar

within 2

			For State Registrar		Marylan		artmen rtificat			and M	ental Hyg	giene Reg. No.	2007	11564
	Physici		1. Decedent's Name (First, Middle DOROTHEA		ERDEL						2. Date of Dea Month March	Day	Year	3. Time of Death 2:00 p M
1	/Media		4a. Facility Name (If not institution				4b. City,	Town, or	Location of	of Death	Haren		ounty of Death	
			7106 Allison S						r Hil				rince G	eorge's
D	Funeral		5. Social Security Number 219-78-5965	6. Sex 7	. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month, Day	v, Year)	Coui	
	Director		Usual Residence of Decedent		82						08-06-1	1924	Net	herlands
	arylaneshow	_	10a. State 10b. County		· ·	y, Town or Lo								10d. Inside City Limits
	he Ma 28a-f	ecto	Maryland Princ	e George's	La	ndover						10- Oil		1 X Yes 2 No
	with 1	Dir	7106 Allison	Street			10f. Zip	0784				U.S.	en of What Coul	ntry ?
	death ms 2: r mus	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13.			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		I. Race - Americ	
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pu	be file	Be	17. Father's Name (First, Middle,								(First, Middle,	Maiden Si	urname)	
Z	hould id Mer marke matic	To	Dirk Buskermo	and place and the second second		19b Maili	na Address	(Street s		ia Ma		ar City or T	Town, State, Zip	n Code)
Ma	1 and 2 s Health an tem 27 is l	i a	Adrianus L. V		ouse	1								yland 20784
Jre,	S = = 0		20a. Method of Disposition	٥ 🗆 🗀		Place of Dispo emetery, cre	osition (Nar	ne of other plac	e)	D	ate	20c. Loca	ation - City or To	own, State
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.	l y	1 🕅 Burial 2 □ Cremation 4 □ Donétion 5 □ Other (S _l		ate	e of l			i i	3/28	/2007	Silve	er Spri	ng, Marylan
Balt	permit Depart Import any in	l ,	21. Signature of Funeral Service	// /		- 1	2. Name an							imore Avenu
	22200		23a Parti. Enter the disease, of		UIH91 used the death						e, P.A.		ttsvill	e, MD 20781
	Physician		Immediate Cause (Final	only one cause on eac	ch line.				3,			,		Approximate Interval Between Onset and Death
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	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of	r as a consequ	uence or):								
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9	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outco	amo of proces	2007						- 1		
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P.O.	that the de sed by the a detached	hysi	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□Unknow										
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n o	ding Ph n. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month,	Injury , Day Year)	28b. Time o Injury	f 2	8c. Injury Work			28d. Describe h			
Sio	Attending Physician: r death. ector: After this certifics by the funeral director, p	catio	2 Accident investig 3 Suicide 6 Could n	ation	f injury - At ho	uma farm str	M		Yes 2□I		206 1 10	N	N	
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	To the Hospital or within 24 hours aft To the Funeral D completely filled in		29a. Certifier 1 Certifyin	g Physician: To the b	est of my kno	wledge, deat	h occurred	at the tin	ne, date an	d place, a	and due to the	cause(s) a	nd manner as s	stated.
	the Ho iin 24 the Fu	Medical	one)	Examiner: On the bas and manne	er stated.	tion and/or in				th occurr	ed at the time,	date and p	place, and due t	to the cause(s)
	Viit viit con	2	29b. Signature and title of certifier	Alla	5	hipman	290	. License			;		signed (Month,	
	(3)		30. Name and address of person	U. UTT	of death (Ita-	23a) /Tuna	Drint)	D28	079			Marcl	h 27, 2	007
W			Francine A. H					i1 C	ourt	Lar	go. Mar	vlan	d 20774	
į	Sta		31. Date filed (Month, Day, Year)	32. Red	gistrar's Signa	Marie ANT	<u>, , , , , , , , , , , , , , , , , , , </u>				, , , ,,,,,	,		
	Registi	rar	MAR 28 2007	allen .	10.									

Maryland 21215-0036

more,

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year) MAR 2 2 2007

KIRVIN

Vans

29b. Signature and title of certifier



fallermy Res

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0057908

29d. Date signed (Month, Day, Year)

ST MICHABLE W)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 26, 2007 Chen-Chen Wu 6:20pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10 Capricorn Court Derwood Montgomery 5. Social Security Number 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, Days Months Hours 1⊠M 2□F 522-69-8049 72 15, Feb. 1935 Taiwan Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland | Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 by Funeral 10 Capricorn Court <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2K Married 1 ☐ Yes 2 ☑ No Specify Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chi-Shui Wu Ching-Ying Lai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Yueh-Hsiang Wu (Spouse) 10 Capricorn Court, Derwood, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/30/07 Alexandria, Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 8 Months Metastatic Liver Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 1∐ Yes 2K No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖼 Residence 6 Other (Specify) Hospital: 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 🖾 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Physician /Medical Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

the Medical

death with

2 should be filed within 72 hours after or and Mental Hygiene.

Is marked other than "natural", or iten

1 and 2 should be f Health and Mental I

permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trauonce.

Baltimore, Maryland 21215-0036

burial-tran and attending physician for use as the buria signed by the a

requires that the death certificate be executed

Box 68760

P.O.

Records,

Division or Vital

60

Examine Physician/Medical ģ After this certificate has been s funeral director, page 2 should Completed Be 2 r To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and liftle of certifier

D 53642

March 27, 2007

A TT 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

932 Hungerford DRive #11A, Rockville, MD 20850 Xiao Zhou, M.D. 31. Date filed (Month, Day, Year)

State Registrar

Medical

egistrar's Signature

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Director 225-18-1189	6:10 a ^M ath George's Inthplace (State or Foreign Country) 10d. Inside City Limits 1 N Yes 2 No Country? Interican Indian, inte, etc. hite s/Industry oyed Zip Code) C 20009		
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1 Yes 2 No 9 Unknown elivery Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 F			
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25. Was case referred to medical examiner? 1 Yes 20 No	ecify)		
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289. Place of Injury - At home, farm, street, factory, office 291. Coation (Street and Number of Parties) 292. Certifier 293. Certifier 294. Check only one) 295. Coation (Street and Number of Parties) 296. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 297. City or Town, State) 298. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 298. Certifier (Check only one) 299. Certifier 290. Certifier 290. Date signed (More of Injury - At home, farm, street, factory, office 291. Cocation (Street and Number of Parties) 291. Cocation (Street and Number of Parties) 291. Cocation (Street and Number of Parties) 291. Cocation (Street and Number of Parties) 291. Cocation (Street and Number of Parties) 291. Cocation (Street and Number of Parties) 292. Certifier 293. Certifier 294. Date signed (More of Injury - At home, farm, street, factory, office 295. Cicy or Town, State)	as stated. se to the cause(s)		
and manner stated. 29c. License number 29d. Date signed (Mor	nth, Day, Year)		
D25019 3-73-07			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Den 14. Labianau La mo 7 to t Etembria Place, Landon	mo 20206		
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signatu			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:30 P^M **Physician** 25 2007 WALKER MARCH LILLIAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 ☐ M 2 🕱 F Yrs. WASHINGTON, DC 73 OCT. 17 1933 578-52-9726 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1X Yes 2 No Funeral Director PRINCE GEORGE'S FT. WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20744 6310 ARIVEN COURT 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No BLACK Specify. Specify: Completed by 3 ☐ Widowed 4 🗓 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **GOVERNMENT** COMPUTER PROGRAMER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TINSLEY GERTRUDE IINKNOWN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6310 ARIVEN COURT FT. WASHINGTON, MARYLAND 20744 Department of Heah.
Important: I flem 27.
any injury or other Health tem 27 I RICHARD L. WALKER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State RESURRECTION CEMETERY03-31-2007 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 21. Signatuje of Funeral Service Licenses 716 KENNEDY STREET N.W. WASHINGTON, DC 20011 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Duemmia disease or condition resulting in death) /Medical Due to (or all a consequence of): Arteriosclerotic heat Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 ☐ Yes 21 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Plnpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral 27. Manner of Death 28c. Injury at Work? Certification: After Injury 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

the death certificate be executed Box 68760, P.O. Division or Vital Records, Hospital

Baltimore, Maryland 21215-0036

spital or Attendi ours after death. neral Director: A

To the Hospital within 24 hours a To the Funeral I completely filled Medical D State Registrar

29b. Signature and title of certifier

29c. License number

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Decrifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D35206

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11701 Livingsom Road Fort WARHINGTON MANYLAND T. TANNER MY William

31. Date filed (Month, Day, Year MAR 28 2007

29a. Certifier

(Check only

and manner stated.

George Robert Ward

Please Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health and

All Copies Are Legit	ole.		1570
d Mental Hygiene	2001	l.	1570

		- For State Registrar		Certific	ate of D	eath			Reg.	No.				
Physicia	an/	Decedent's Name (First, Middle								2. Date of Death Month Day Year				
∕ledical Exami		George							arch 26, 2	007		1930 hrs		
		4a. Facility Name (if not institution Peninsula Regional Me				City, Town, or Li Salisbury	ocation of	Death	4c. County of Death Wicomico					
Funeral				(In yrs. last bir		f Under 1 Year	If Under		•					
Director		218-20-3091	1 X M 2 F	0	Yrs.	Months Days	Hours	Min.	9/18/1	L926	Foreigr Cou	Maryland		
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5-0036 Ited within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-			of working life. [,		
5-0036 led within 72 Hygiene. other than '	휌	12	_	·	otside	e Salesn	nan			auto	moti	ve parts		
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (Larry Ward							ayland					
D 21 should and Mer 7 is man		19a. informant's Name/Relationsh	nip (Type, Print)	19	b. Mailing A	ddress (Street	and Numb	er or Rural	Route Numb	er, City or To	wn, State,	Zip Code)		
MD d 2 sho lth and n 27 is aumati		Alice Julia Ward/wife 207 Woodcrest							alisbu	ry, MD 21804 20c. Location - City or Town, State				
imore, MD 21216 Pages 1 and 2 should be fill ment of Health and Mennal H tant: If item 27 is marked or other traumatic event, i		20a. Method of Disposition 1 X Burial 2 Cremation	crema	tory or other	place)		Da							
		4 Donation 5 Other Sp		Park		emorial		3/31/				bury, MD		
Baltimore, permit. Pages I at Department of He Important: If ite	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral H								Home Professional Association				
	Harry (4) 301 Blow MIII har Ballissa									ury, r	עב עו	804 Approximate Interval		
Physician /Medical	ı	failure. List only one cause	on each line.	ne death. Do n	ot enter the	node or dying, s	oucii as cai	i diac oi Tes	piratory arres	t, shook, of th	bait	Between Onset and Death		
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a consec	wood of							_	- Bedair		
			b.	querice or).										
	盲	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):										
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nted d ansit	ŭ	events resulting in death) Last Due to (or as a consequence or): d.												
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760, ficate be g physic the bur	Med	IF FEMALE:	23c. If yes, outcom							23d. Date of	of delivery			
687 ertific ding p	au/	23b. Was decedent pregnant in th past 12 months?	I LIVE DITTI	una of dooth	2 Fetal		_Ectopic	pregnancy		ay Year				
Box 68's death certification attending	sici	1 Yes 2 No 9 Unk	nown 9 Unknown	me or deam	5 Othe	(Specify)								
ords, P.O. Bc w requires that the des as been signed by the a should be detached fo	된	Part II. Other significant conditi		but not resulting	ng in the und	erlying cause gi	ven in Par	t I.	23e. Did tob	obacco use contribute to the cause of death?				
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COr law r has b	du		autopsy prior to completion of cause performed? death?											
Continue of the continue of									No	1 🗸 Ye	es 2 No			
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ing Phys After thi	: To	1 Yes 2 No 27. Manner of Death	28a Date of Injur	v 28b	Time of Inju		y at Work?			w injury occu				
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Divis pital or At ours after d eral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street								^{ate)} Salisbury, M	D			
Hospi 24 hou Fune tely fi	ျှင	29a. Certifier 1 Certifying Pl	nysician: To the best of my	knowledge, d	eath occurre	d at the time, da	te and plac	ce, and due	to the cause	(s) and mann	er as stat	ed.		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Exa	miner: On the basis of exam and manner stated.	nination and/or	investigatio	n, in my opinion,	death occ	curred at the	e time, date a					
F > F 3	§ €	29b. Signature and title of certified	er			29c. License						nth, Day, Year)		
03		- Therefore	U. Thead JA	unt.		O.C.N	И.Е.			March 27	, 2007			
9		30. Name and address of person		eath (Item 23a)	44.0		Aima e -	4D 04004					
6		Theodore M. King, Jr.			miner 1	11 Penn Str	eet, Bal	urnore, N	VID 21201					
	tate	31. Date filed (Month, Day Year)	9 2007 32. Registrar	s Signature	Mars	Mi)								
Regis	al GI	3,			FINE PAR	The state of the s								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie [] 1- Registrar Amend #31 per FCHD 03-29-20 Pertificate of Death CNM 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** Alleta 305 Irlene Welsch March 200 6 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mount Airu If Under 1 Year If Under 24 Hrs. Mount Arru 0,10011 Lonen 6. Sex) 1 □ M 2⊠ F 8. Date of Birth (Month, Day, Year) Jan. 26, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Yrs Director 511-12-0713 90 Jan. 1917 Kansas Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Frederick Mt. Airy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4041 Lomar Drive 21771 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Earl Botkin Gladys Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Ann Welsch / Daughter 4041 Lomar Drive Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April , 2007 4 □ Donation 5 □ Other (Specify) Quantico Nat. Cemetery Quantico, Virginia 22. Name and Address of Facility 21. Signature of F Stauffer Funeral Homes, P.A 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Enysician disease or condition resulting in death) neumonic Week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ ed bluods ere brovascular accident 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 20 No 1 Yes 1□ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Certification: To 4 Massing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death.

Director: After din by the full 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours af To the Funerel D To the Hospitel Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0054423 March 28 30. Name in faddres of person who completed cause of death (item 23a) (Type, Print) Daybokak Circle
32 Egistrar's Signature 6030 Feinberg Clarks Ville MS 31. Date filed (Month, Day) Year State Registrar

			For State				l / Depa	ırtmeni	of H	ealth a		ental Hygi		07	11572		
			Registrar				Cer	tificate	OT L	Jeath			g. No.		T 0 5 15 15		
f	Physicia		1. Decedent's Name (First, Middle, Last) Ruth Burton Winterstein									2. Date of Death Month	Day 29	2007	3. Time of Death 4:30pm M		
	/Medic Examin		4a. Facility Name (If not institution		4b. City,	Town, or	Location of	of Death		4c. Cour	nty of Death						
	LXAIIIII	C1	118 Wintacre Farm Lane						ersv	/ille			Quee	n Ann	es		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe					If Under Months		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day,		9. Birth	place (State or Foreign intry)		
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	P .		Usual Residence of Decedent			10.00	-								404 Lealer Challing		
	anylar show	_	10a. State 10b. County			10c. City,	Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
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	er de Item	Funerai	11. Marital Status	. 13. V	Yes, spec	ent of Hi	spanic Ori n, Mexican	n, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.							
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힏	be filed within hal Hygiene. ed other than event, the Mg	ВеС	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	ne (First, Middle, Maiden Surname)					
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aZ	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o eny injury or other treumatic ave OREs.		19a. Informant's Name/Relations	nip (Type, Print)		114	19b. Mailin	ng Address (Street and Number or Rural Route Num					mber, City or Town, State, Zip Code)				
	and 2 Balth and 27 in 27 i		Norma Weller	- Daugh	ter		101	Norwo	ood 1	Drive	Su	dlersvil	le, M	D 216	68		
Baltimore,	of He of He roth		20a. Method of Disposition	2 Domousi tr	20b. Place of Dis				osition (Name of matory or other place)				Oc. Locatio	. Location - City or Town, State			
Ĕ	Pages nent of int: If it iry or o		1 Burial 2 Cremation 4 Donation 5 Other (S)		city) Sudlersv:			sville			4-1	-2007 S	udler	dlersville, MD			
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m	88 5 5 8		Kik Y	Help	els	ريا		130 S _I			Ches	tertown,	MD 2	21620			
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications th	at caused on each lin	the death.	Do not ente	er the mode	e of dying	g, such as	cardiac c	or respiratory arre	st,		Approximate Interval Between		
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Вох	ath c	ian	23b. Was decedent pregnant in the past 12 ponths?	1⊟Li	ve birth	2 Detail of time of dea	death 3□	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					23d. Date of delivery Month Day Year				
o.	the e	ysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown														
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ds,	sign d be	b b	My pertensin									1 ☐ Ye	1 Yes 2 No 3 Probably 4 Unknown				
Ö	requ peen shoul	ete										24a. Was an	s an 24b. Were autopsy findings available				
Division of Vital Records,	hes hes ge 2 :	Completed by Physician/Med										autopsy performed death?			completion of cause of		
<u>a</u>	n: The ficete											1 Yes 2 No			2 No		
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O	ding th. Afte	ţ	1 Natural 5 Pendin 2 Accident investig	9	(Month, Day Yeer) Injury				28c. Injury at Work? M 1 ☐ Yes 2 ☐ No			28f. Location (Street and Number or Rural Route Number					
/ISI	or Attending Physicien: The i after death. Director: After this certificete he in by the funeral director, page	fica	3 ☐ Suicide 6 ☐ Could I	ined 200. P											ral Route Number,		
ă	al or s after I Olre	Certification:	4 Homicide	Di							City or Town, State)						
	To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending phycompletely filled in by the funeral director, page 2 should be detached for use as the		(Check only 2 Medical	Examiner: On the	e basis o	f examination	rledge, death	occurred vestigation,	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the ca ed at the time, da	use(s) and ite and plac	manner as	stated. to the cause(s)		
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18	Registr		APR 0	4 2007	A Comment	teno .	B A		10								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Adrean Waters 22,2007 March 19:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 6. Sex 1 → M 2 □ F If Under 24 Hrs. Hours Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 218-07-1034 88 Director 05/31/1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 XYes 2 No Directo Maryland Prince Georges Brandywine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12105 Martin Road 20613 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Engineer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Levin James Waters Mary Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trau once. David Waters/Son 3604 Village Dr.North Upper Marlboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Maryland Veterans 03/29/2007 Cheltenham, Maryland 21. Signature Funeral Service Lice 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 40 COY 019 /Medical Due to (or as a consequence of) Examiner erosc Sequentially list conditions, if any, leading to immediate cause. Enter Uncorping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **Z** No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1, Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide

or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed and the burial-tran attending physician for use as the buria ed by the a page 2 should be der certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, within 24 hours a To the Funeral L

show

r 28a-f show notified at

Hygiene. other than "natural", or items 23a or ent, the Medical Exeminer must be r

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Pages 1 and 2 should

Maryland 21215-0036

Baltimore,

the

State Registrar

Medical

29b. Signature and title of certifier

determined

4 Homicide

29a. Certifier

29c. License number

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DO037066

30. Name and address of person who completed gause of death (Item 23a) (Type, Print) m. D 61880 xon Hill Satt 701 0 ton Kill mo 20745

strar's Signature 31. Date filed (Montl

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar	State of Mar		artmen rtificat				- 1	Reg. No.	007	the second	-	574
1	Physici	an.	1. Decedent's Name (First, Middle, La							 Date of Dea Month 	Day	Ye	ear		of Death
	/Medic		Olive Mae Walthe							1ARCH	25	500	<u> </u>	3:50	7 4 M
	Examir	er	4a. Facility Name (If not institution, give	·		4b. City,		Location o			4c.	County of I			
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	Funeral Director			Sex 7. Age (1	94 Yrs.	Months	Days	Hours	Min.	B. Date of Birt (Month, Da OCt. 2	3, 19	912	Court	ity) Urgin	e or Foreign
	land		10a. State 10b. County	1	0c. City, Town or L	ocation							1	0d. Inside	City Limits
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	28a	Funeral Director	10e. Street and Number		reserre	10f. Zip	Code				10g. Citi	zen of Wha	t Cour	ntry?	
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	me 2	ner	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spec	rfy Yes or No- ican, etc.)	-	14. Race -			,
9	or its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give		1 Yes		Specify:	i, rueito n	icari, etc.)		Black, \	AATIIG,	etc.	
8	rai',	i by	3 X Widowed 4 □ Divorced	Year or Dates:		10 105	2 X 1 140	зреспу.				Specify:	Wh	ite	
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N N	C 00 00 10		Julia W. Busick/	**		-				Elkton,	-			(Code)	
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Ba	Department of the partment of		As (Y	1171	R.	T. F	oard	and	Jones	, Inc.					
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	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Demen	consequence of):									Interval E Onset an	
	rcuted nd	Examiner	Sequentially list conditions, in the sequential of the sequential	c.	conse uence of :										
8760,	tate be executed by sicien and the burial-transit	cai	resulting in death) Last	Due to (or as a o	consequence of):								ļ		
Box 68	The law requires that the death certificat tte has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12_months?	23c. If yes, outcome of	Fetal death 3	□Ectopic p					1	23d. Date o		ery Day	Year
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of Vital Records,	ires t signe d be c	þ	ATRIAL FIBRU	_	not roodking in the	an out, mg	sauso give	J		10					□Unknown
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<u> </u>	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		-	(Check only o					
of	this aldin	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatie		JA _	4/4/14/		e 5 Resid			(Specit	(y)	
n	fter ne	lon	1 Natural 5 ☐ Pending	(Month, Day Y	/ear) 28b. Time (Injury	M	28c. Injury Work	γαι ∢? Yes 2□		3d. Describe I	now injui	y occurred			
Division	deat deat ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	De Place of Injun	· At home, farm, si (Specify)			163 2		Bf. Location (: City or Tox			or Rura	al Route N	lumber,
_	Hospit 4 hour Funera tely fills	edical Co		hysician: To the best of miner: On the basis of each manner state	xamination and/or in										e(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier					number			29d. Dat	e signed (/	Month,	Dey, Year	r)
}			1 Kmin OK			1	1281	119			MAR	LH 26	, 2	007	
	5		30 Name and address of person who Ropway Down, I	completed cause of dea	th (Item 23a) (Type	Print)			I his				-J	,	
	Sta	ite rar	31. Date filed (Month, Day, Year) MAR 2. 8 20	3. Registrar'	s Signature	ules				1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4-8-2007 4:50 A^M Henry Oliver Zimmerman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 13816 White Oak Ridge Hancock If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-18-1923 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 □ F 83 WVa Director 236-22-5756 Usual Residence of Deceden deeth with the Marylend permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Maryler Department of Heelth end Mentel Hyglene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow with Injury or other treumatic event, the Medical Examinar natatibe notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Washington Hancock MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21750 U.S.A. 13816 White Oak Ridge Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hancock 12 Letter Carrier US Post Office 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဥ Levin Oliver Zimmerman Emma Farris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Virginia Zimmerman 13816 White Oak Ridge, Hancock MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Great Cacapon Great Cacapon Cem. 4-11-07 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22 Name and Address of Facility Hunter-Anderson Funeral Home 36 S. Green St, Berkeley Springs WV 25411 massen 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NOITIMANI **Physician** /Medical Due to (or as a consequence of): Examiner VASCONAR DOMONTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ettending physicien end for use es the burial-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should I MUIZNOTABIUM 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No : After this certific funerel director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No ဠ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: d in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospitel o within 24 hours at To the Funerel Di completaly filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9 700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 WEST HIGH STREET, HANCOCK MD BRIAN R. STANLEN

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) APR 1 1 200

MD

32. Registrar's Signature

			1 - For State Registrar	State of	Marylaı		artmen rtificate				Mental	Hygie Reg	21111/		576
	Discontinu		1. Decedent's Name (First, Middle	e, Last)							2. Date Mon	of Death		3. Time	of Death
	Physici /Medi		Irving	Al	ston						Apri	14,	Day Year 2007	7:40) Рм
	Examir		4a. Fecility Name (If not institution	n, give street and numb	oer)		4b. City,	Town, or	Location	of Death			4c. County of Deat	h	
			Joseph Richey				Balt								
	Funeral		5. Social Security Number	6. Sex 7. 1 ☑ M 2 ☐ F		. last birthday) Yrs,	If Under Months		If Under Hours	Min.	i (Mor	of Birth th, Day, Yo	ear) Co	hplace (State untry)	-
	Director		246-44-8539 Usual Residence of Decedent		78	113.					Aug.	20,	1928 Nort	h Caro	lina
	land		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside (City Limits
	Man	ţō	Maryland Balt:	imore	Ca	tonsvi	lle							1 🗌 Ye	s 2 1 No
	1 28 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rec	10e. Street and Number				10f. Zip	Code				10g.	. Citizen of What Co	untry?	
	hours after death with the Maryland ture!; or Items 23s or 28s-f show al Examiner must be multified at	by Funeral Director	29 Clinton Hill	Court			212	228				τ	J.S.A.		
	dea me	ner	11. Marital Status	12. Was Decede			Was Deced	lent of Hi	spanic Ori	igin? (Sp	ecry Yes	or No-	14. Race - Ame		
98	or it	F	1 Never Married 2 ☐ Marr				1 ☐ Yes 2		Specify:		nican, e	,	Black, White		
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9	Hygin Hygin		17. Father's Name (First, Middle,	Last)		DIS	зартес	i.	18 Mothe	er's Nam	e (First &		den Sumame)		
=	Mental Mental arked c	To Be	Soloman Alston	1							avis				
<u>Z</u>	2 should and Men is marke eumatic	-	19a. Informant's Name/Relations			19b. Mailir	na Address	(Street a				Vumber C	ity or Town, State, 2	in Code)	
	1 end 2 Health a am 27 is		Ada Alston	(Sister)									e, MD 212		
ē,			20a. Method of Disposition			Place of Dispo	sition (Nam	ne of			Date		. Location - City or		
Ë	Pages nent of ant: if its arry or o	- 8	1 ☐ Burial 2 ☐ Cremation 4 ☐ Dogetion 5 ☐ Other (S)			ston Fa				4/9	9/07	W	arren, NC		
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Records, F	been signed should be dei	ed by P	Part II, Other significant condition	Secontributing to death	h but not res	sulting in the ur	nderlying ca	iuse givei	n in Part I.		23e.	Did tobace	co use contribute to		death? Unknown
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ב ב	Miter t		27. Manny of Death 1 Natural 5 ☐ Pending	28a. Oate of I	njury Da <i>y Year)</i>	28b. Time of Injury	28	lc. Injury Work	at ?	- 1	28d. Desc	cribe how i	njury occurred	112/	u
Vision of Vita	ler death. Irsctor: After this	cat	2 Accident investig 3 Suicide 6 Could n	ot by			М		es 2⊡ñ	-				- 6	
Division of		Certification;	4 Homicide determine	building,	etc. (Specif						City	or Town, Si			nber,
To the Hoos	within 24 hours after	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the be xaminer: On the basis and manner	or examina	owledge, death tion and/or inv	occurred a estigation, i	t the time in my opi	nion, deat	d place, th occurr	and due to ed at the	the cause time, date	e(s) and manner as and place, and due	stated. to the cause(:	s)
F	To	2	29b. Signature and little of certifier	Pauni	/ M	D	29c.	License 7/3	number	9		29d.	Date signed (Mghth	Dey, Year)	
			30. Name and address of person v	the completed cause of	f death (Iten	n 23a) (Typ), F	rint V	WAR.	10	RI	M	affin	Inil	7/7/	Q'
	¥	e	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	1 11114	n/	VVV	4/	14	10	4101	1140	1040	

			For State Registrar	State	of Marylan		artmer <i>tificat</i>					gien Reg. N	20	07	1157	7
	Physici		1. Decedent's Name (First, Midd Constance M.								2. Date of De Month April 9	eath D	ay 2007	Year	3. Time of Death 9:52 AM	М
	/Medio Examin		4a. Facility Name (If not institution Stella Maris	n, give street and n	umber)		Ti	Town, or			APLII .		c. County			
	Funeral Director		5. Social Security Number 213-20-1083 Usual Residence of Decedent	6. Sex 1 ☐ M 21X F	7. Age (In yrs. 82	last birthday) Yrs.	If Unde Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da May 4,	ay, Yea		Cou	place (State or Fore ntry) yland	ign
	Maryland a-f show ifled at	ctor	10a. State 10b. County	1		y, Town or Local Baltimo									10d. Inside City Lim	
	s 23a or 28 nust be not	eral Director	10e. Street and Number 3939 Roland Av		cedent Ever in U.	C 12 V	10f. Zij	2:	1211	igin2 (Sn	noifu Von or N		US.	A	ntry?	
036	ours after de ral", or Item Examiner r	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	rried Armed I	Forces? 5 2 X) No Give		f Yes, spe		Specify:		ecify Yes or No Rican, etc.)	<i>,</i>		k, White,		
1215-0036	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or Items 23a or 28a-f show iatte event, the Medical Examiner must be notified at	Completed		nt's Education est grade completed College	(1-4or 5+)		ient's Usu kind of wo DO NOT u make:	ork done d se retired)	ition Juring mos	st of work	ing		Kind of Bu		dustry	
yland 2	should be filed and Mental Hygi s marked other umatic event, t	To Be Co	17. Father's Name (First, Middle Francis Fabin			,					e (First, Middle ce Key	, Maide	en Surnam	ne)		
Mar	ss 1 and 2 should b of Health and Ment item 27 Is marked r other traumatic e		19a. Informant's Name/Relation: Cynthia Brooks			45 E	. For	d Co		Parky	al Route Numb	MD	2123	4	,	
altimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (:	Specify)	m State	Place of Dispo cemetery, cren	natorý or	other place			Date		Location -			
g	Department Impo		21. Signature of Funeral Service 23a. Part Enter the diseas , o shoo or heart failure. Lis	0/16/1	100	- Ba	ltim	ore,	MD	2120			11tim	ore S	Approximate	
	Physician /Medical Examiner		Immediate all se (Final disease or condition resulting in death)	a. CER	EBROVASC o (or as a conseq	ULAR A									Interval Between Onset and Death	
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ion or vital	hy His I di	tion: To Be	25. Was case referred to medicine examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pendi invest	Hospital: 1 [□ Inpatient 2 □ te of Injury onth, Day Year)	ER/Outpatien 28b. Time of Injury		28c. Injury Work	r: 4□ Nu	ursing Ho	n (Check only me 5 ☐ Res 28d. Describe	idence			fy) HOSPICE	ı
DIVISION	ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t oletely filled in by the funera	Certification:	4	nined 200. Pla	ce of injury - At ho lding, etc. <i>(Specil</i>	y) 					City or To	wn, Sta	ite)		al Route Number,	
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)	with con		29b. Signature and title of certifi	/		- 00-) (T		<u>D</u> (13	72	5	29U. L	4/9	107	Day, Year)	
	Sta	te.	30. Name and address of person DR. TARIO MAH 31. Date filed (Month, Day, Year	100D 230	use of death (Iten DULANE Registrar's Signa	Y VALL). T	IMON	IUM,	MD 210	93_		_		
	Regist		APR 1 9	20	Bessel &	1 200	BARRES									

DHMH 17 Rev 1/2001

CONSTANCE AUER

ORIGINAL

			For State Registrar	State of M	arylan		artment rtificate			and M	lental Hy	giene Reg. No.	000	7	11578
	Physici	an	1. Decedent's Name (First, Middle,	ŕ							2. Date of D	Day	Ye	ar	3. Time of Death
ANT S	/Medic	al	John Allan Bychi 4a. Facility Name (If not institution, o				45 00 3	F		f Darath	April	11,	200		12:40 A™
J.	Examin	er	8401 Dogwood Rd	ive street and number)					Location of Mill	Death			County of D Balti		غ
3-	Funeral Director			Sex 1X M 2□F	e (In yrs. 68	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of 8 (Month, D April	irth lay, Year)	9.	Birthpla Counti	ace (State or Foreign Ty) MD
Allen Ar	put N		Usual Residence of Decedent 10a. State 10b. County		10c Cit	v. Town or Lo	cation							10	d. Inside City Limits
	Maryla f sho	io	MD Baltimo	re		dsor M								10	1 ☐ Yes Ž No
	or 28a	irec	10e. Street and Number		*****	abol 11	10f. Zip	Code				10g. Citi	zen of What	Count	ry?
	ath wil	ral	8401 Dogwood Rd				212					USA			
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☐ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Deced If Yes, spec 1 ☐ Yes 2	_	ispanic Ori in, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V Specify:W	Vhite, e	tc.
21215-0036	2 hou latura ical Es	ted t	15. Decedent's	Education		16a. Dece	dent's Usua	l Occupa	ation	4 - 4 4 - 1		16b. Ki	nd of Busine		
215	ithin 7 ne. nan "n	Completed	(Specify only highest selementary/Secondary (0-12)	College (1-4or !	5+)		kind of wor DO NOT us			t ot worki	ng	_		_	
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and	ld be f ental f ked of	To Be	John Bychich	,,,					Julia			o, maiden	ourname		
Maryland	2 should be i and Mental is marked o aumatic eve	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address				l Route Num	ber, City o	r Town, Stat	te, Zip (Code)
	1 and 2 Health a em 27 is other tra	,	Barbara L. Bychi	ch/Wife		8401	Dogw	boo	Rd Wi		r Mill				
OLE	Pages 1 nent of H ant: If ite ury or otl		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3			Place of Dispo cemetery, crer					ate		cation - City		,
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	1	4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lic			ro Cre	Name and	Addres	e of Facilit	3/			timor	e, l	MD
ñ	per Imp any		1 Color	ensee C. Todd	Dri	ng C	remati 99 Fre	ion eder	Socie	ty c	of Mary 1timor	land	Inc.	8	
· P	Physician		23a. Part1. Enter the disease, or of shock, or heart failure. List or Immediate Cause (Final disease or condition	mplications that caused by one cause on each li	ne.	h. Do not ent	er the mode	of dying	g, such as	cardiac o	or respiratory	arrest,			Approximate Interval Between Onset and Death Multiple
	/Medical Examiner		resulting in death)	Due to (or as			wil	L.V.	7	t or C.	-			u	munn
6	Examiner	je je	Sequentially list conditions,	b. Due to (or as	8 000850	ilence off:									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,										
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8760,	cate b	dical		d										-	
Box 6	certified plant pl	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregna	ancy							23d. Date of	deliver	v
о. В	he death the atter	Physician/Mec	in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pre Other (spe						Month		Day Year
<u> </u>	that the photographic that the photographic	y Ph	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying ca	use give	en in Part I.		23e. Did	tobacco u	se contribut	e to the	cause of death?
rds	en sign	ed by									1/4	Yes 2[□No 3□] Proba	bly 4 Unknown
Records,	law re las be	Completed									24a. Wa	opsy	24b. Were	e autop	sy findings available pletion of cause of
<u>a</u>	n: The lcate h										per 1∐ Yes	formed? 2 No	deat		2□ No
Vita	sicertif irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Hospital: 1 ☐ Inpatie	ant 2 🗆	ER/Outpatien	+ 3□00	Δ Othe	or.		(Check only		3 Dath #	2	
פֿ	g Phy ter this neral d	n: To	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of Injury		Bc. Injury Work			me 5 Res 28d. Describe		<u>`</u>	<i>эреспу)</i>	'
Sior	endin sath. or: Aff	atio	1 Accident 2 Accident 3 Suicide 5 Pending investigat 6 Could not	on bo			М	1 🗆 1	Yes 2 □ I	No					
Division or	al or Att after de il Direct d in by 1	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At ho c. (Specif	ome, farm, str	eet, factory,	, office				(Street and own, State		r Rural	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier 1 > ertifying (Check only one)	Physician: To the best aminer: On the basis o and manner st	f examina	wledge, death ition and/or in	n occurred a vestigation,	at the tim in my o	ne, date an pinion, dea	id place, ith occuri	and due to the	e cause(s) e, date and	and manne place, and	r as sta due to	ited. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	11/			29c.	License	number			29d. Dat	e signed (M	lonth, D	Pay, Year)
			> Hicholas Ke	ul re which	M	1)		<u>D3</u>	850	9		aps	111	-	2007
	H		30. Name and address of person wh	completed cause of d	eath (Item	23a) (Type,	Print)	PATI	(40,0	10	tu for	lun	bus.	100	2/10/
	Sta	te	31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	ature _		1116	ITEU		10	INCOM	VIVA)	1110	or will
	Registr					EO A.	20 0 B								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 1101 **Physician** VIBLA 04 KRIG65 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Pasadena 3391 Littleton Way 3C If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year 1 M 2 F Days Hours Months 7,1912 NC Sept. 240-03-6847 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 28e-f show r then "naturel", or Items 23a or 28e-f shov tre Medical Examinatives be coulded at 1 ☐ Yes 2 No Anne Arundel Director Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code U.S.A. 21122 3391 Littleton Way 3C death by Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Factory Seamstress other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 is marked oth any jury or other traumatic event 900g. Eleinore Everhart Jerome Nimrod Hutchins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3391 Littleton Way 3c Pasadena, MD 21122 Mrs. Bettie Leister /Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 11, 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 2007 Glen Burnie, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Singleton Funeral Home, P.A. MO1357 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ConceA Sequentially list conditions, in any, leading to inimediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12/months? Month Day 0 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٤ this After thi 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Mapner of Death Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 | Homicide after within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b Signature and thie of certifier 29d. Date signed (Month, Day, Year) 29c. License number Chief Medical Officer 10 D 21438 Hospide of the Chesapeake 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaPenta, M.D., 445 Defense Highway, Annapolis, MD 21401 32. agistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** MARIE Κ. BERES APRIL 7:24A /Medical 8 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OAKCREST VILLIAGE PARKVILLE BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 3 □ F 215-07-8472 98 Yrs Director 3-25-1909 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count 28a-f show r than "natural", or Items 23a or 28a-f shorthe Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 WALTHER BLVD APT 1118 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 2 ☐ No ş Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) filed within College (1-4or 5+) HOMEMAKER 12 OWN HOME Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked THOMAS PIEKARCZYK 2 KATHERINE (POLEK) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any Injury or other trauonce. KATHLEEN BERES/DAUGHTER 3120 CHURCH ROAD MITCHELLVILLE, MD 20721 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1. Burial 2 Cremation 3 Removal from State Donation 5 ☐ Other (Specify) HOLYROSARY CEM. 4-12-07 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME CHESACO AVE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonio **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consect Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No To the Hospital or Attending Physician: certifica Be 25. Was case referred to medical examiner? 26. Place Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 🛹 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar (Check only one)

chosha

31. Date filed (Mont)

29b. Signature and title of certifier

IXOn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Boulevard Partille, MD Z1234

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Apr. 5-30 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town. or Location of Death 4c. County of Death **Examiner** Balta Dry Hospital 01 Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Months 1₩ M 2□F Director 213-18-6596 11, 1921 86 Maryland Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show iral", or items 23a or 28a-f shov Examiner must be notified at 1√2Yes 2 No N/A Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3333 Chestnut Avenue 21211 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the folds and Mental Hygiene. Thent of Health and Mental Hygiene. Sint: If item 27 is marked other than "natural", or itee 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Fireman Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Robert Burns Helen Kilpatrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Burns Wife 3333 Chestnut Avenue, Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H important: If ite any Injury or of 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 4/12/2007 Catonsville, Maryland permit. 21. Sign we I Funeral Service 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician V conal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 ☐ Other (specify) this certificate has been signed by the a ral director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of within 24 hours after death.

To the Funeral Director: After of the funeral pile in by the funeral completely filled in by the funeral com 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

-obeman

31. Date filed (Month, Day, Year)

APR 1 2 2007

Hospital

m. D

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 7 2007 April IRIS Ρ. BENJAMINE 17:15 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death BALTIMORE 1407 E. FAIRMOUNT AVENUE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 20XF NORTH CAROLINA 66 JAN 6 1941 216-40-1716 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 □ No BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21231 1407 E. FAIRMOUNT AVENUE Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: RT.ACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DHMH CLAIMS PROCESSOR 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) IRA BENJAMINE ETHEL M. GALLOWAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1512 E. Baltimore St., Baltimore, Maryland 21231 Vivian Benjamine/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAMILTON BURIAL GRDN | 04-14-07 WILSON, NORTH CAROLINA 21. Slanatur of Funeral Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Deart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death -ardio Vascular Disease Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (a a consequence of): perlipidemin Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 MYes 2 No 3 Probably 4 Unknown Ven tricular 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed attending physician and for use as the burial-transit o م Records, page 2 s certificate Division or Vital Hospital or Attending Physician: this After t death.

To the Funeral Director: completely filled in by the hours

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier

Funeral

Director

ms 23a or ? must be r

permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Examinar muonce.

Physician /Medical

Examiner

Maryland 21215-0036

Baltimore,

with the Maryland r 28a-f show notified at

State

Registrar

29c. License number

1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier CO MD

D50770

St. Baltimore, MD 21202

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edith M. Vargo MD 1000 E. Eager

31. Date filed (Month, Day, Year)-

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMN) TTPM:/, perFH, 375, 1/16/08 WS
State of Maryland? Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 7:15 P.M Joel Nathan Badger, Sr. 2007 April 6 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stevensville Queen Annes 702 Chesapeake Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)
Jan. 20, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1947 Days Hours Months Mary Land 1 X M 2 ☐ F 214 46 2159 60 -54 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Stevensville Maryland Queen Annes 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 702 Chesapeake Drive U.S.A. 21666 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 XYes 2 No If Yes, Give Year or Dates: t Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) State of Maryland 4 years Correctional Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Velma Eagle Vance Badger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberlyn Pratesi / Daughter Woodbine, Maryland 21797 2000 Sleepy Hollow Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 4/11/2007 Glen Burnie, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. al Service License 21. Signatura 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
17 Months Immediate Cause (Final disease or condition resulting in death) Concer Colon Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death

Privsician /Medical Examiner

> burial-transit and

as the 957

detached for

the attending physician

signed by

peen

of or Attending Physician: after death. Director: After this certifica

within 24 hours a To the Funeral I Fo the Hospital

be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Be

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Certification:

Physician

/Medical

Examiner

Director

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nath any injury or other traumatic event, the Medica.

the Maryland

with

death

72 hours after

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

☐Yes 2☐No 9 Tuknown

25. Was case referred to medical examiner?

1 Natural

29b. Signature

28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pendina 1 ☐ Yes 2 ☐ No

investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

ASSURBOUM MEDICAL ONCOLOGY

29c. License number

29d. Date signed (Month, Day, Year) HOUI 10, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hoping Comer Conter ROSS C. DONEHOWER, MD

ertifier

Beltzmane, MD

DIRECTOR,

Registrar

07-02633 Gerald Baker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gerald Baker	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.										
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	d Baker		2. Date of Death Month April 6, 200	Day Year 7	3. Time of Death 1905 hrs					
	4a. Facility Name (if not institution, give street and number Harbor Hospital Center	r) 4	b. City, Town, or Location of De Baltimore		4c. County of Death						
Funeral Director	5. Social Security Number 219 74 7931 6. Sex 1 7. A	ge (In yrs. last birthday) 41 Yrs.	If Under 1 Year If Under 24 Months Days Hours I	Hrs. 8, Date of Birth 07/23/	(MM/DD/YYYY) 9. Bir 1965 Foreig						
id how any ce.	Usual Residence of Decedent	10c. City, Town or Location Baltimor				10d. Inside City Limits 1 X Yes 2 No					
the Maryland a or 28a-f show tified at once.	10e. Street and Number 3810 S. Hanover Street		10f. Zip Code 21225	10ς	U.S.A.	ntry?					
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. To the real of the stand of the control of the standard	11. Marital Status 1 Never Married 2 Married Armed Forces 1 Yes 2 3 Widowed 4 X Divorced If Yes, Give Year	s? If Ye 2 X No	s Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pue Yes 2 X No specify:		White, etc.	ite					
5-0036 ed within 72 hours aft fygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12) College (1-4 or 10 th	r 5+) during mo	's Usual Occupation (Give kind ost of working life. DO NOT use ane Operator		16b. Kind of Business/l	ndustry tals Company					
21215-0036 Mental Hygiene. marked other than marked other than event, the Medica	17. Father's Name (First, Middle, Last) Gerald J. Ba			etty Willi	ams	7'- 0-4-)					
MD 21, and 2 should be saith and Men em 27 is marraumatic eve	19a Informant's Name/Relationship (Type, Print) Betty O'Dea / Mother 20a Method of Disposition	530 M	unroe Circle G	len Burnie		1 21061					
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, To Be	1 Burial 2 Cremation 3 Removal from S 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	State crematory or oth Bayview (ner place)	04/11/2007 Gonce Fun	eral Servi	e, Maryland					
M 월경토토 Physician /Medical	23a. Part I. Enter the disease, of complications that cause failure. List only one cause on each line.	ed the death. Do not enter the		ghway Bal	timore, Ma:	Approximate Interval Between Onset and Death					
Examiner	or condition resulting in death) Due to (or as a consequentially list conditions,		cocaine use								
ted ansit Examiner	if any, leading to immediate cause. Enter Underlying Dauss (Disease or injury that initiated events resulting in death) Last Due to (or as a con										
te be executed ysician and burial - transit	☐ AMENDED ☐ #Z3a,27,2	28a-f, perME, g8	867, 5/24/07 TT		23d. Date of deliver	y					
D. Box 6876(the death certificate by the attending phy ched for use as the bached for use as the Physician/Me	23b. Was decedent pregnant in the nast 12 months?	2 Fe	tal death 3 Ectopic pre	egnancy		Day Year					
Aecords, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for 1 Completed by Physii	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	inderlying cause given in Part I.		2 ✓ No 3 Pro						
Records, I The law requires fricate has been sig page 2 should be Completed			26,Place of Death (Ch	autops perforr 1 ✓ Yes 2	prior to death?	completion of cause of					
of Vital ng Physician: After this certi nneral director n: To Be	27. Manner of Death 28a. Date of II	njury	3 DOA Other, N	ursing Home 5 F	Residence 6 Othe	er:					
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the ledical Certification: To Be Completed by Physician/M	Pending Accident Investigation Suicide Natural Pending Investigation X Could not be	/2007 Fnd 6:30) pm 1 Yes 2 X No et, factory, office building, etc.	28f. Location (S		ural Route Number, City					
To the Hospi within 24 hou To the Funet completely fi	29a. Certifier 1 Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of examiner state	xamination and/or investiga	rred at the time, date and place, tion, in my opinion, death occur	and due to the cause red at the time, date a	and place, and due to t	he cause(s)					
A) A	29b. Signature and title of certifier When the Undle		29c. License number O.C.M.E.		April 7, 2007	onth, Day, Year)					
Colon	30. Name and ad ress of person who completed cause of Margarita Korell MD. Assistant Medic.	al Examiner 111 P	enn Street, Baltimore, N	MD 21201							
State	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AMES 3. Time of Death Day DISSEAU Year /Medical 2.15 AM MARCH 30 200 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death BALTIMORE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 4c. County of Death HARBOR HOSPITAL N/A 5. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 ☐ F 214 64 1013 Director August 6,1953 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28s-f show other traumatic event, the Medical Examinar must be notified at Maryland 10d. Inside City Limits N/A Director Baltimore 1 ▼Yes 2 No 10e. Street and Number 10f. Zip Code 1133 Monroe Circle 10g. Citizen of What Country? 21226 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 🏻 Divorced 'natural', 1 ☐ Yes 2X No Specify Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown Steel Erector Stee1 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be fill ment of Heelth and Mental Hight: if Item 27 is marked out Be 18. Mother's Name (First, Middle, Maiden Sumame) James Marvin Boisseau 0 Charlotte (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Mortimer 4221 Audrey Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 ② Cremation 3 ☐ Removal from State 20c. Location - City or Town, State ŏ 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4/4/2007 Baltimore, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BLEED ONINE /Medical da Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical USB as I IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy 23d. Date of delivery ed by the e P.O. 4☐ Pregnant at time of death 5 Other (specify) Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed of Vital Hospital or Attending Physician: 1 Yes 2DNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death Certification: 28a. Date of Injury (Month, Day Year) Division 28b. Time of Natural 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) M-C-J-MID 001 2007 MARIH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUBHASH BUSE 3001 HARBOR HOSPITAL, SOUTH HANDUER STREET MD-2125 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3. Time of Death Day 2007 Month Helen C. Berman /Medical April 4, 9:40 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 26, 1 **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2XF Director 215-01-0618 88 1918 Maryland Usual Residence of Decedent 10a. State 289-f ehow 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28e-f shov treumatic event, It a Mudical Examinal must be notified at 10d. Inside City Limits MD Baltimore Parkville 1 ☐ Yes 2 🗙 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Marned Black, White, etc. Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 1 Yes 2 No Specify. White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene Important: if tiem 27 ie marked other then "ne eny injury or other treumatic event, ILE MILLE ODGE. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Francis Caslin 2 Margaret McDermott 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Berman (son) 1510 Long Quarter Ct. Lutherville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Grds. _ 04/13/2007 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Dogation 5 ☐ Other (Specify) Timonium, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. And 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1050 York Road, Towson, MD Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) **Physician** demention End Stake /Medical Month Due to (or as a consequence of) Examiner Sequentially list conditions, and any loaning to infinite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence or): The law requires that the death certificate be executed anding physicien end use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant ŏ 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐ Pregnant at time of death been signed by the should be detached 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? USUCUL 2 No 3 Probably 4 □Unknown certificate has 24a. Was an 24. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No or Attending Physician: 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient Certification: To 1 Yes 2 No Other: ursing Home 5 Residence 6 Other (Specify) this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death, To the Funerel Director: A completely filled in by the fu 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address Person who completed cause of death (Item 23a) (Type, Print) (cho men 8100 Walth 21234 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar APR 1 2 2007

DHMH 17 Rev 1/2001

BERMAN

		,	for State Registrar	State of M	arylan			nt of H		ind M		giene,	007	11587	
	Dii.	100	1. Decedent's Name (First, Middle, Last	")							2. Date of Dea	th	Year	3. Time of Death	
	Physici /Media	100	Anna B	elle		Br	oy le	S			April	08 ^{Day}	2007	11:15 a ^M	
Sagar S	Examir	_ =	4a. Facility Name (If not institution, give 2202 Brown Road				Fi	nksbı				Car	of Death		
	Funeral Director		5. Social Security Number 213-26-1247 Usual Residence of Decedent	7. A	ge (In yrs. I 77	Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birth DeC. 17	¹ 929	9. Birth	nplace (State or Foreign がずand	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural; or Iteme 23a or 28a-f ehow ont, the Weddel Examinar must be coulded as	Director	10a. State 10b. County Md. Carroll 10e. Street and Number	g	p Code				10a Citizen	of What Co	10d. Inside City Limits 1 ☐ Yes 2 🛣 No				
	ath with	ral Dir	2202 Brown Road					21048				10g. Citizen of What Country?			
036	ours after des ral', or Iteme Examene in	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 21☐ If Yes, Give Year or Dates:	t Ever in U. ? No	4	Was Dece If Yes, sp 1 Yes	**	spanic Orig n, Mexican Specify:	jin? (Spe , Puerto i	icify Yes or No- Rican, etc.)		Race - Amer Black, White ecify:		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehov mith jury or other traumatic event, the Medical Experiment must be cartified at DACE.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12		5+)	16a. Dece (Give life. Own	kind of w DO NOT	ial Occupa ork done d ise retired,	urina most	of worki	ng		urant	ndustry	
Maryland 2	12 should be filed within hand Mental Hygiene. 7 is marked other than "Iraumatic event, Ira Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men	To Be C	17. Father's Name (First, Middle, Last) Peter J. McElr				18. Mothe	_	(First, Middle,	ddle, Maiden Surname)					
, Mar	1 and 2 sho Health and Iom 27 Is my other traums		Mr. Daniel K. Broy	aniel K. Broyles/ Husband 2202 Brown Rd. Finksburg, Md. 2										ip Code)	
Baltimore,	Pages 1 and the sunt: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Place of Dispo emetery, crer lar Gr	natory or	other place		4-14				n - City or Town, State			
Balti	permit. Pag Department Important: I any injury o	21. Signature of Funeral Bervice Licensee 22. Name and Address of Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204													
8760, 1	Physician with personal person	icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as Due to (or a)	s a consequence of a consequence of the consequence	uence of):	mi.							Approximate Interval Between Onset and Death 2 W (& K S	
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	death 3	Ectopic Other (s	pregnancy				23d	Date of deli	very Day Year	
	quires that n signed b uld be deta		Part II. Other significant conditions co			ulting in the u	nderlying	cause give	en in Part I.			bacco use		the cause of death?	
Division of Vital Records,	: The law requir cete has been si , page 2 should	Completed by									24a. Was a autop perfor 1 Yes	med?	4b. Were au prior to d death? 1 ☐ Yes	topsy findings available completion of cause of	
Vita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or				
Section Part										cify)					
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of it	njury - At ho atc. (Specif)		reet, facto	ry, office			28f. Location (S City or Ton	Street and N n, State)	umber or Ru	ral Route Number,	
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical C	29a. Certifier 1 ☑ Certifying Phy (Check only one)	ysician: To the besiner: On the basis and manner s	of examina	wledge, deat tion and/or in	h occurre vestigatio	d at the tim	ne, date and pinion, deal	d place, th occurr	and due to the ded at the time, d	cause(s) and pla	d manner as ice, and due	stated. to the cause(s)	
	To the To the comp	Ň	29b. Signature and title of certifier					c. License						n, Day, Year)	
			Shign M. Con	~~			1	2005	6156	ン	6	Apri	19,2	2007	
	10		30. Name and address of person who of SUZUNE CALLER	completed cause of	death (Item	1 23a) (Type,	Print)	cr(xs	Stv	rit	Balt	inor	, Ma	14 land 2126	
The State of	Sta Regist		31. Date filed (Month, Day, Year) APR 1 2 20	32 (eg ist	trar's Signa	ture	aste)	,							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.") 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 **Physician** 4:05 P M Lucy Cleaver Brightman 9 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 XF 88 Yrs. Nov. 15, 1918 Kentucky Director 400-03-7537 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Gaithersburg 1 ∑Yes 2 No Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Russell Avenue #914 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No δ Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Actress Film & Entertainment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Paul Cleaver Elizabeth Brown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel C. Brightman 13304 Bondy Way, Darnestown, Maryland 20878 20b. Place of Disposition (Name of Montgomery or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 12. 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cremătoriúm, Inc. 2007 21. Signature of Funeral Solvice Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, MD 20814-350 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** April 8-9 ROV /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner as the burial-transit and resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2ENo 2 INo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1. Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 s after death. in by t

Baltimore, Maryland 21215-0036

within 24 hours at To the Funeral C Hospital the

State Registrar

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe

20065333

1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

April

2007

11119 Rockville Pike #401, Rockville, Maryland Donmez Petek, M.D.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

A STATE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 50 a M Bailowich Evelyn Irene 104 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roseda Franklin Square 5. Social Security Number Hospital Center ltimore If Under 1 8. Date of Birth (Month, Day, Year) 11/19/1935 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 🗙 F 223-30-5395 71 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified at 10a State 10b. County Maryland Baltimore Middle River 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e ral" or items 23a Examiner must b 2125 Oakland Road 21220 U.S.A. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ ☑ 0 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 and 2 shout be filed within 72 hours after c Health and Mental Hygiene. em 27 is marked other than "natural" or the 1 Never Married 2 Married 1 ☐ Yes 2XXXio Maryland 21215-0036 Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe Gant Nellie Irene Hooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Bengies Road, Baltimore, Maryland 21220 Peter Bailowich, III (Son) Itimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 04/10/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Fune al Silvace II ensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate the Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** Years /Medical Due to (or as a consequence of): Examiner monarcy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons uence of Examine The law requires that the death certificate be executed physician and s the burial-trans Diabetes ears Due to (or as a consequence of): Physician/Medical attending pt for use as th IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No page 2 s 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No ို 2 XER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: completely filled in by the f

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

MD

(Check only

1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

APR12

29c. License number D0061662 29d. Date signed (Month, Day, Year) 04/07/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

9000 Franklin Square Drive Baltimore, Md 21239 longthan tanson 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical

07-02367 Perry Barnes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 1405 hrs Perry Barnes March 27, 2007 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Middle River 9805 Tailspin Apt. K **Baltimore County** 5. Social Security Numberunk 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Davs Hours Director 1 X M 2 F 46 Yrs Oct 3, 1960 Countryland Usual Residence of Decedent è 10a State 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f show 1 Yes 2 X No es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene
If item 27 is marked other than "natural", or items 23a or 28a-f she her traumatic event, the Medical Examiner must be notified at once Baltimore Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9805 Tailspin #K 21220 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black. White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes Specify: black Widowed If Yes, Give Year Divorced Yes 2 X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done unk16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 construction 12 0 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Howard Mitchell Barnes Mary Frances Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Virginia Avenue Baltimore, MD Emmanuel Barnes/brother 20b. Place of Disposition (Name of cemetery. 20a Method of Disposition 20c Location - City or Town, State Baltimore, crematory or other place) Pages 1 of F 1 Burial 2 Cremation 3 tant: 4 Donation 5 X Other Specify: in state 21. Sincture of Euroral Service License nald S. W State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death Upper astrointestinal hemorrha e due to chronic alcohol abuse Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED urial #23a,27, perME. g866, 4/18/07 TI of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be IF FEMALE 23d. Date of delivery phy the b 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day this certificate has been signed by the attending director, page 2 should be detached for use as t Fetal death Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? 2 No this certificate ✓ Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: thin 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other₄ examiner? 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: Scene Inpatient 1 🗸 Yes 2 No uneral After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 1 Yes 2 No To the Funeral Director: completely filled in by the Investigation Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 28, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Mélissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 15:22 2007 Jeanne Banton /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav **Funeral** Min. Months Days Hours unk 1 □ M 2 🔀 F 61 July 29, 1945 Director 218-48-0142 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner many and injury or other traumatic event, the Medical Examiner many and once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21230 2104 Parksley Street Funeral 14. Race - American Indian, unk 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: white þ 3 Widowed 4 Divorced Cities uni Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21230 2104 Parksley Street Baltimore, MD Theresa Banton/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of Eurieral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street *x*ector 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 No 2 certificate 1 TYes 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 22 ER/Outpatient 3□ DOA ို After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A death. 2 Accident filled in by the ould not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number e and title of certifier 29b. Signa

StateRegistrar

31. Date filed (Month, Day,

2 2007

JOHN STEVEN COLING Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day April 7, 2007 JOHN Medical Examiner 0434 hrs OLLIN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24Hrs. **Funeral** Foreign Virginia Months Days Hours Min Director 01-18-1958 1 M Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No "natural", or items 23a or 28a-f show Examiner must be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10g. Citizen of What Country? Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 No specify ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Curin abarer 0 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) lata 20646 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date place of Disposition (...
crematory or other place)

Notro Cremator 1 Burial 2 VCremation 3 Removal from State netro 12-0 Donation 5 Other Specify re of Fune 0 Fred HILTON P. march Rineral or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and /Medical a Heroin, nordiazepam and alcohol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, hading to inmediate cause. Enter Underlying Cause Dus to (or as a nonsequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and tran sician/Medical X UNPENDED AMENDED 27.28a-f. perME. g866. 4/16/07 TT attending physician or use as the burial The law requires that the death certificate be Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Other₄ examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 After this 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b, Time of Injury Certification: Natural 1 Yes 2 X No in by the 4/7/2007 Fnd 4:00 am 2 🔲 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 📗 Suicide 600 N. Wolfe St. Baltimore, MD filled determined (Specify) Johns Hopkins Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely

State

within 2 To the 1

Tasha Greenberg MD. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

ORIGINAL

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

2007

MID

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

April 7, 2007

Medical

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 26 PM 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death Examiner Dita N/A Birthplace (State or Foreign Country) /8. Date of Birth (Month, Day, Year) March 15, 1956 5. Social Security Number in yrs. last birthday) If Under 24 Hrs. **Funeral** Days Hours Min 1 □ M 2**X** F 220-76-7499 51 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No **Funeral Director** MD Carroll Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2504 Fairmount Rd 21074 USA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas T. Griffith, V Muriel Ross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jennifer Muzik/Daughter 319 North Ferry Point Rd Pasadena, MD 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 4/12/07 Baltimore, MD 22 Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore, MI 21. Signature of Funeral Service Licensee C. Todd Dring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Day thylene /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sels consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknown signed by the period of the pe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has autopsy 1∐ Yes Physiclan: 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day Year) 27. Man er of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 5 ☐ Pending investigation 900 AM April 7, 2007 1∐ Yes 2 🗖 No 2 Accident ingestion of antitreeze Director: the 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completely filled in by the 28f. Cation (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 504 Fairmount Rd Hampstead Maryland 10me. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

5

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

Johns

HOPKINS

32. Registrar's Signature

THE RABOUR

MD

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALSOY

APR 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CHRIST EVELYN PRIL 3:07AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner North West Hospital-Heartland Hospice Randallstown Baltimore If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 143-09-2898 95 Jan. 9, 1912 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 X Yes 2 No Directo Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 1840 Reisterstown Road 21133 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No White Completed by Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator Communication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Krumreich Minnie Knockelman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13605 Royal Crest Rd., Phoenix, MD 21131 Lois Briggs (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/10/07 4 ☐ Donation 5 ☐ Other (Specify) Laurel Grove Mem. Totowa, NJ 22. Name and Address of Facility Moore's Home for Funerals 1591 Alps Rd., Wayne, NJ 07470 21. Sign ture of Funeral Servic Licens rmeur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIORESPIRATORY /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examine The law requires that the death certificate be executed END STAGE CHRONIC OBSTRUCTIVE PULMONARY physician and the bunial-tran DUEASF Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by BLEDDING HYPERTENSION 1 🗌 Yes 2 No 3 Probably certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No DEMENTLY 24a. Was an autopsy performed? 1∐ Yes 2∏ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760, Division or Vital Records, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu completely To the

altimore, Maryland 21215-0036

Registrar

BOONYONG 31. Date filed (Month, Day, Year) APR 1 2

(Check only

29b. Signature and title of certifier

Bonyon



Under

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D19823

BALTIMORE

29d. Date signed (Month, Day, Year)

21215

APRIL 5, 2007

11595

			State of Maryland / Department of Health and M 1- State Registrar Amend Item 23a per dr., g866, 04/12/0/dhb	ental Hyg	iene '	, , , , , ,
			1. Decedent's Name (First, Middle, Last)	2. Date of Deat	h	3. Time of Death
	Physici /Medic		Anna M. Cottrell	Month March 1	8, 2007	12:20 AM ^M
	Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	
			11042 Spyglass Hill Court Mitchellville			George's
	uneral irector		5. Social Security Number 6. Sex 1 M 2 M F 82 Yrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Feb 11,	Year) 9. Birt Co 1925 New	hplace (State or Foreign untry) York
P			Usual Residence of Decedent			
arylar	the state of	-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
e M	Pag-	ecto	MD Prince George's Mitchellville			A
death with the Maryland	23a or 2 at be n	al Dir	10e. Street and Number 11042 Spyglass Hill Court 20717	"	0g. Citizen of What Co USA	untry?
3-UUSO 72 hours after deal	Department or result and wenter rygener. Department of result and wenter rygener. By injury or other traumatic event, the Madical Examinat rulat be nutitied at ODCs.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Sive □ Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 □ Yes 2 □ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: 1	
3-0	netura dicel E	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	ng	16b. Kind of Business/	Industry
within	then he was	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 2 Secretary		GOMORDEO	nt
D #	ont, I	ŭ	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, N	governme Maiden Sumame)	111
5 8	Ked o	To Be	William james Stanley Rosa H	Hartzog		
aryia should	umati		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			
and 2	0 27 l		Paul Lucas/son 11042 Spyglass Hill Co	ourt Mit	chellville	, MD 20717
altimore	ant: If iten ary or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☒ Donation 5 □ Other (Specify)	ate	20c. Location - City or	Town, State
permit.	Importa		21. Signature Fauneral Rylce Licensee Director State Anatomy Board Baltimore, MD 21201		Baltimore	Street
,	ysician ledical		23a. Part1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, to heart failure. List only one cause on each line. Immediate Cause (Final disease or condition as the complete of the comple		est,	Approximate Interval Between Onset and Death
	aminer		Renal Disease			
	-	ner	Sequentially liet conditions: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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A =	phys	edical	d		ĺ	
the death certif	been signed by the attending should be detached for use a:	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
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COLOS w requires	en si ould l			1 □ Ye	es 2.024No 3Pr	obably 4 Unknown
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E E	r: After e funer	atlon	27. Manner of Death 1 Action 5 Pending 2 Accident	28d. Describe ho	w injury occurred	
DIVIS	within 24 uros are rouss are rouss. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Sti City or Town	reet and Number or Ru n, State)	ral Route Number,
Me Hospit	ne Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
Tott	To til	¥	29b. Signature randititle of certifier of Ce		9d. Date signed (Mont	n, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Laure	1 11/01	Bowle MD
	Sta		31. Date filed (Month, Day, Year) 22. Registrar's Signature	MONE	z · way	Domie IIII)
2	Registr	ar	APR 1 2 2007 Share It Species			1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edward Leroy Thomas Crouse 10, 2007 April 1:20 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1809 Winans Avenue Halethorpe Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 08/14/1951 5. Social Security Number . Sex 1 2 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 220-56-8305 55 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Halethorpe 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1809 Winans Avenue 21227 United States Funeral within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.
White 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) is 1 and 2 should be filed within by Health and Mental Hygiene. Item 27 Is marked other than College (1-4or 5+) Supervisor Food Distribution 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Gordon Crouse Vivian Lee Wilt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1809 Winans Avenue, Halethorpe, MD 21227 permit. Pages 1 and 2 Department of Health a Important: If item 27 Is Diane Crouse / wife 20b. Place of Disposition (Name of Meadowridge or other place)
Meadowridge Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ò 4 Donation 5 Dother (Specify) 4/13/2007 Elkridge, Maryland any Injury 21. Sign ture of Funer 22. Name and Address of Facility Am rose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final Physician Arterio Sc disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine burial-transit certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760 physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy 5 in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No Records, P.O. the detached 9☐Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 24a. Was an autopsy perform certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 2 ER/Outpatient 1 Yes 3□ DOA 1 | Inpatient this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1XX Natural 5 Pending investigation 24 hours af er death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

completely filled in by within 24 4

> State Registrar

(Check only

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Trimble H:11 CT. Luthoru: 118, MD 2109? 6

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRILOS 2007 TLORI 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL CENTER RANDALLSTOWN MORTH WEST BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🛛 F MARYLAND SEPT. 16 1929 214-26-3316 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TyYes 2 □ No MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 2307 CHELSEA TERR. 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XXIvo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify: BLACK 3XXVidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEALTH 11th grade NURSE/MOTHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LESLIE THOMAS LILLIE THOMAS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley Currie/Son 5211 Hecock Ave., Loraine, Ohio 44055 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) METRO CREMATORY 04-09-07 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. al vares 1206 W NORTH AVENUE Tatil. Enter the disease, or complications that caused the death. Do not enter the mode of duly, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ence of): Due to (or as a consequ 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Labetes me (litus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ŽUnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform malnutrition 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical **Examiner**

the death certificate be executed

Box 68760,

Division or Vital Records, P.O.

Physician

/Medical

Examiner

Director

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-dical Examiner must be notifiled at

Baltimore, Maryland 21215-0036

d 2 should be filed w th and Mental Hygies 7 Is marked other th

Pages 1 and 2 ment of Health a ant: If Item 27 Is ury or other trai

permit. Page Department o Important; If any Injury or

ician and burial-trans attending physician for use as the buria ate has been signed by the page 2 should be detached

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors.

Examiner

Physician/Medical Completed Be 2 Certification:

DHMH 17 Rev 1/2001

State Registrar

Medical

4 ☐ Homicide

29b. Signature and title of certifier

29a Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RADCLIFFE THO MAS M.J. 4000 4000 W NORTHERN PKWY

31. Date filed (Month, Day, Year)

> Lascyte Wilhomas

APR 12

32. Registrar's Signature

07-02699 James Chelsey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day April 7, 2007 **Medical Examiner** 2352 hrs **JAMES** CHESLEY 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Franklin Square Hospital Rosedale **Baltimore County** 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign MARYLAND Months Days Director Hours Min 213-20-0145 1 X M 2 F 81 08/20/1925 Usual Residence of Deceder Ž. 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene ant. I filem 27 is marked other than "natural", or items 23a or 28a-f she ro other traumatic event, the Medical Examiner must be notified at once MARYLAND rector BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2607 PENNSYLVANIA AVENUE 21217 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 XX No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: BLACK à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th grade MEAT CUTTER POULTRY 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) MORRIS CHESLEY MARY DORSEY 19a. Informant's Name/Relationship (Type, Print) ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha S. Andrews/Daughter 5802 Leith Walk Ave., Baltimore, Md., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 XXCremation 3 Removal from State crematory or other place) Department or Important: injury or oth METRO CREMATORY 4 Donation 5 Other Specify 04-11-07 BALTIMORE, MARYLAND 21. Signature of Fuperal Service 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Part I. Enter the disease, opcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one caus Between Onset and /Medical Immediate Cause (Final disease Hypertensive atherosclerotic cardiovascular disease Death Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any leading to immediate Due to for as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit The law requires that the death certificate be executed Physician/Medical M_{AMENDED} #1, perME, g868, 6/28/07 TI #23a,PII.27.perME, G868, 6/18/07 TI signed by the attending physician be detached for use as the burial -X UNPENDED Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? δ Pneumonia complicating hypopharyngeal carcinoma status post 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available surgery, diabetes mellitus autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical the Hospital or Attending Physician: 26 Place of Death (Check only one) Be Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 Ves 27 Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural death, 5 Pending 1 Yes 2 No Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City hours after 3 Suicide 6 Could not be or Town, State) within 24 hours a determined __ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Jeeel O.C.M.E April 10, 2007 Mip Toste.

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Tasha Greenberg MD.

31. Date filed (Month, Day, Year)

7

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year 1108 a 0-/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr 20, 1921 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 C. **Funeral** 1□ M ½□ F 215-22-5882 85 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location *OHe 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23a or 28a-f eho: other traumatic event, the Madical Examinar cust be notified at Baltimore Md Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5411 Plainfield Avenue 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Black Be Completed by Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Associate 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r Sales Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)

James Stewart 18. Mother's Name (First, Middle, Maiden Surname)

Marie Macon 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5411 Plainfield Avenue Baltimore, Maryland 21206 Pages 1 and 2 s ment of Health an ant: if Item 27 is Dorothy Clowney Niece 20a. Method of Disposition

| Burial | Cremation | 3 | Bamoval from State

4 | Donation | 5 | Other (Specify) 20b. Place of Disposition (Name of cometery, crematory or other place)
Mt Zion Cemetery Date JAK 20c. Location - City or Town, State permit. Pages Department of Important: If It eny injury or o 4-18-07 Md Signature of Fyneral Service Licer 22. Name and Address of Facility Miller's Metropolitan Chapel P.C. 1639 North Broadway Baltimore , Maryland 21213 2. Part1. Enter the diserve, or complications that caused the deam shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death onot enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner 90 Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? X Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after within 24 hours To the Funeral 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven 131 VD, Ball-MD 21 239 5661 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

APR 1 2

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:47 PM Sireta Curry April 2007 10 /Medical 4a, Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Agnes Hospital 8. Date of Birth (Month, Day, Year) 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 👿 F 213-20-1404 Director 83 Jul 22, 1923 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Baltimore Director N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21230 1820 Spence Street Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 X If Yes, Give Year or Dates: 21 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 MoNo Specify: Specify: þ Black 3 Movidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilhelmina Henry Frank Henry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Burrell Daughter 601 Charraway Road Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 Removal from State 04/16/07 Baltimore, Maryland 5 Other (Specify) Arbutus Memorial Park 4 Donation 22. Name and Address of Facility 21. Sonatu Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Pleural Physician day /Medical Due to (or as a consequence of) Examiner ung mass Sequentially list conditions Sequentially list condition and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. **2** 2 🗆 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has autopsy perform 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 28a. Date of Injury 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day 1 ☐ Yes 2 ☐ No in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) APR 1 2 2007 900 S. Caton 32. Tegistrar's Signature

April D ORIGINAL Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0930 M 04 04 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Timore 017 UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 ☐ F So. Carolina 248-60-4270 Jul 30, 1940 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show be notified at 1 Kes 2 No Baltimore Director N/A Marvland 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö U.S.A. 21230 item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be 2924 Rayshire Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food King supermarket filed withir Hygiene. Cashier 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F Julia Davis Davis ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4110 6th Street Baltimore, Maryland 21225 f Health Rhonda Davis Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages the Department of Hamportant: If ite any injury or ot 1 ☐ gurial 2 ☐ Cremation 3 ☐ Removal from State Lansdowne, Maryland 04/09/07 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery Funeral Serviced icense 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 2 23a. Part . Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final METASTATIC LELOMY OS ARCOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending philips of the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division or Vital Records, 1 Yes 2 No 3 Probably 4 Munknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 2 □ No 1∐ Yes Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 Minpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA P After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. I Director: / d in by the f 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I filled To the Hospital 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29b. Signature and title of certifier A44176

State Registrar

DHMH 17 Rev 1/2001

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STREET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

KACHEL

31. Date filed (Month, Day, Year)

22

S. GREENE

Registrar's Signature

5888

Registrar

1

31. Date filed (Month, Day, Year)

APR 1 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN KOTTAR TH2 L
300) SUNTH, HANNOVER STREET, BALTIMORE,

32. Registrar's Signature

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BALTIMORE, MARYLAND

		For State Registrar	State of Maryla		artment of I rtificate of				iene	7 11603
		1. Decedent's Name (First, Middle, Las	1)				2	. Date of Deat	h	3. Time of Death
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Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location	of Death	_	4c. County of I	Death
		Stella Maris Hos			Dulaney		-		Baltimo	
Funeral Director		1/8-05-86/6	7. Age (In yrs 3xM 2□ F 93	s. last birthday) Yrs.	If Under 1 Year Months Days		Min. M	Date of Birth (Month, Day, larch 2	^{Year)} 1914	Birthplace (State or Foreig Country) Pennsylvania
>		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	ecation					10d. Inside City Limits
shov ad at	2	Maryland Baltimor		altimor						1 □ Yes 2X N
28a-f notifii	Funeral Director	10e. Street and Number			10f. Zip Code			11	0g. Citizen of Wha	t Country?
a or		2118 Rockwell Av	renue		2122	8			USA	,
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h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med	To Be	Springer	Craig	T			innie			ook
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r of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑			osition (Name of matory or other pla		Dat		20c. Location - Cit	
tant: jury o		4 ☐ Donation 5 ☐ Other (Specify) Se		Cemeter		4/13/		•	Pennsylvania
Department of Health a Important; If Item 27 is any Injury or other trainonce,	1	21. Signature of Funeral Service Licen	See				-		k Funera re, MD 2	
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signed b	d by Pi	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	ınderlying cause g	iven in Part	I.		oacco use contribu es 2□No 3[ite to the cause of death? ☐ Probably 4X Unknow
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within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Deposited determined	28e. Place of injury - At	Injury home, farm, st	M 1	Yes 2		f. Location (St	reet and Number	or Rural Route Number,
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in 24 hoi he Fune pletely fi	Medical		ysician: To the best of my kinner: On the basis of exami and manner stated.		nvestigation, in my	opinion, de				
きち	Σ	29b. Signature and title of certifier			29c. Licer	ise number		2	9d. Date signed (/	Month, Day, Year)
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10		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	Print)					
	ata	DR. TARIO MAHMOO 31. Date filed (Month, Day, Year)	D 2300 DULAN 32. Registrar's Sig		LEY RD.	TIMON	NIUM,	MD 2109	93	
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APRIL 7, 2007

PAUL CRAIG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AFRIL. øğ. 10:00P M 2007 **Physician** Elizabeth Ann Conco /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Saint Joseph Medical Center Towson 8. Date of Birth (Month, Day, Year Jan 9, 192 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min West Virginia 1□ M XXF 1924 83 233-30-2819 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 TYes 2 XINo Directo Owings Mills Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21117 9773 Groffs Mill Drive Apt. 217 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2√ Married White 1 ☐ Yes 2 🔀 🗙 No Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill put of Health and Mental H. It. If Item 27 is marked oth y or other traumatic event Be Helen R. Bevans Care Leo Adkins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 4154 Double Tree Lane, Hampstead, MD. Katherine Conco (daughter) 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 → Burial 2 □ Cremation 3 □ Removal from State Andrew Russian Orth.04/13/07 Baltimore, Maryland St. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FUCK OWSON FUNETAL FOME, INC. 21. Signature of Funeral Service Li 1050 York Road, Towson, Maryland 21204 23a. Part1. Errer the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death ed by the a detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Division or Vital Records, 2 CARDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 has 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔀 No 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No M To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death, 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

APR 1 2007

29b. Signature and litle of

31. Date filed (Month, Day, Year)

KHOSROW TABAISI.

7601 OSLER DRIVE TOWSON, M.D. 32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

D46356

29d. Date signed (Month, Day, Year)

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #7,8,20a-c,22,per H, Copies Are Legible.

Amend #15,17,19,510 State of Maryland / Department of Health and Mental Hygiene. Amend #15,17,18&19a&b Per Ana BD G866 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** COPELAND TERRY 0440 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CUMBERLAND WESTERN COLRECTIONAL INSTITUTION ALLEGANY If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days 217-84-2756 12 M 2□ F Ol-03-1965 Maryland ← 43 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 ☐ No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13800 McMullen Hgwy SW 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: black 2 Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk 12 unk 0 laborer 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) -unk Be Leon Copeland Amanda Rogers 19a. Informant's Name/Relationship (Type, Print) Linda JOhnson/sister WEstern Gorrectional I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5000Hampshire Avenue Baltimore, MD 21207 13800 McMullen Hgwy Cumberland, MD 21502 Institute 20b. Place of Disposition (Name of 20a Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4/13/2007 Catonsville, MD
22. Name and Address of Facility Howell F. H. 4600 Liberty Heights Hwy. 4 Donation & Mather (Specify) in state Metro Crematory icensee Wade √ Director Baltimore, MD 21201 21207 art1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) · AINS Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physiclan/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ALAS DEMENTIA COMPLEX, CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? RENAL INSUFFICIENCY 1 🗆 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Lother (Specify) INFIRMAR) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055881 esserra MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13800 McMullen HWY CUMBERLAND MD 21502

State Registrar

31. Date filed (Month, Day, Year)

APR 1 2 2007

32. Registrar's Signature

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death

altimore, Maryland 21215-0020

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P.O. Box 68760,

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Attending Physician:

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completely filled To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr. 2866, 04/12/07dhb
Red. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 35p /Medical 07 4c. County of Death not institution, give street and nu Town, or Location of Death **Examiner** Memoria DITO Year 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2**X**F 17 215-30-5376 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 es 2 No Director timore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2121 by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ıral", or items ′. Exa⊞iner mu Race 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 ☐ Divorced the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ary (0-12) College (1-4or 5+) Ses 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked traumatic e ပ rence 2 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 3906 Alameda, Balko MD 20a. Method of Disposition = º 1X Burial 2 ☐ Cremation 3 ☐Removal from State Department of Important: If any injury or Farrison Forces 4 ☐ Donation 5 ☐ Other (Specify) INGS MILLS, MI 21. Signature of Funeral Service Licensee S YOLK 2d, Bode of dying, such as cardiac or respirator Infarction 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or heart failure. List only one cause or each line. **Myocardial** In Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** anawa 4 neurs /Medical Du to (or v a consequence of): Examiner Sequentially list conditions, if a ny leading to infinitelate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oue to for as a consequence off Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Nonknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 1∐ Yes 2□No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Many fer of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 🗌 No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 24 the 29c. License number M 49 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 MI. DANIEL 30. Name and address of person who completed cause mpleted cause of death 23a) (Type, Print) 2 Panwa IMORE Month, Day, Year) APR 1 2 2 31. Date filed (Month, rar's Signature State 2007 Registrar

Funeral

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Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2007 Elliott Mildred M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale

If Under 1 Year If Under 24 Hrs.

Dave Hours Min. Baltimore Franklin SQUARE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🟋 156-22-8273 Usual Residence of Decedent 10/25/1930 76 New Jersey 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Howard Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20723 S. A. 7882 Hammond Parkway Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hoffman e Number, City or Town, State, Zip Code) New Jersey 08859 20c. Location - City or Town, State Hazlet, New Jersey Maryland 21221 Approximate Interval Between Onset and Death iratory arrest, 23d. Date of delivery Month Day 3e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Magner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04-10-2007 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 9000 Franklin Square Drive Baltimore Maryland 21237 odit 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar

Division or Vital Record

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To the Funeral Director: completely filled in by the fi

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Division of Vital Records, P.O. at or Attending Physician: The law requires that it all price death. The law requires that it all price death. The function: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director.										_ 1	Yes	2 No 3 P	robably 4 🗸 Unknown		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Wilbert Ford 11:22 A M Farl 04 10 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1924 E. 30Th Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 ☐ F 212-18-0388 Director 09/03 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified to once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 No Specify Black Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Graphics 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kuth Ford Kobert Lee ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30th Street Baltimore MD 21218 Bobbie Ford 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD Garrison Forest -117 157 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Voughn C. Greine Funeral Sentices York Road Battemore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** -allene Consectue theor mortis Due to (or as a consequence of): cardamyo Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (07 mory Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ၉ 1 ☐ Yes 💆 No Other: 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Division or Vital Records, P.O. Box 68760, been signed by the should be detached certificate has birector, page 2 s funeral director, this After

/Medical

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

State Registrar

3 Suicide

29a. Certifier

31. Date filed

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

(Month, Day,

APR 1

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1:13 taller 0 Calvin 10 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA Dactmere Nunsing Home Green If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 229-48-2586 68 Months 1 M 2 ☐ F Yrs. man Director irginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits if Hygiene. cther then 'natural', or iteme 23e or 28e-f ehow vent, the Modical Exercites must be notified at Baltimore 1 Nes 2 No NIA Completed by Funeral Director ma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 2400 permit. Pages 1 and 2 should be liled within 72 hours alter death v. Department of Health and Mental Hygiene. Instrument of Health and Mental Hygiene. Instrument if item 27 is marked other then "natural", or iteme 23a and injury or other traumatic event, the Mydical Exercises 2008. Inden 12. Was Decedent Eyer in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Blac Baltimore, Maryland 21215-0036 Specify. Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) anitorial worker NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Waivley MINNIE ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stafe, Zip Code) niece , md, 21128 Yark Hall 20b. Place of Disposition (Name of Date 20c. L. Carlion - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Trinity undalk, md -17-07 emeler 4 ☐ Donation / S ☐ Other (Specify) 21. Signature of Funeral Service Licens . Name and Address of Facility Fred HILTON 70 Funeral Home Dalto, ind, 21229 march 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** holom gio carcinomia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Darta URIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a donsequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit ONHENU JONOVY 0 physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? MARRIA certificate has autopsy mema 1 Yes 1 ☐ Yes 2 1 No Alter this certification and director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: 27. Manner of Death 28b. Time of 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: completely lilled in by the I 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of ceptified 29c. License number 29d. Date signed (Month, Day, Year) D0064788 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of RUYAL AUE, BALTIMORE naima 1000 W 32. Registrar's Signature 31. Date filed (Month, Day, Year)-State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			For State	State of Maryland / D	•		ntal Hygi	ene	11611
			Registrar 1. Decedent's Name (First, Middle, La		Certificate of E		Re Date of Death	g. No 0 0 /	3. Time of Death
	Physici /Medic		RANDOLPH	FLETCHE	R		Month 0 4	Day Year	618 AM
	Examin		4a. Facility Name (If not institution, give Loyien Nursi	41	4b. City, Town, or	Location of Death		4c. County of Death	A.
Ī	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs. last birti	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Date of Birth	Year 9. Birth	blace (State or Foreign
	pu »		Usual Residence of Decedent 10a, State 10b) County	10c. City, Town	or Location				10d. Inside City Limits
	e-f eho	ctor	Ad auch	rusael Ha	nover)				1 ☐ Yes 2 THO
	death with the Maryland rma 23a or 28e-f ehow r must be notified at	Funeral Director	100 Street and Number 75/4 Daxx	rop at	10f. Zip Code	76	10	g. Citizen of What Cou	194y? 7 -
000	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar carment of Health and Mental Hygiene. ortant: if Item 27 ie marked other than "natural", or Iteme 23a or 28e-1 ehow carment if Item 27 ie marked other than "natural", or Iteme 23a or 28e-1 ehow injury or other traumatic event, the Madical Examinar must be notilised at injury or other traumatic event, the Madical Examinar must be notilised at 8.	þ	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 [\$\sum_{\text{Ves}} 2 \sum_{\text{No}} \text{No} \text{157-} If Yes, Give Year or Dates: \$\sum_{\text{Ves}} 0 \text{60}\$	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Speci , Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify:	
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Mary	2 a = 2		19a informant's Na le/Relationship	Type, Print) 19b.	Mailing Address (Street A	AUCT 7	Number,	City or Town, Sta o Z	21076
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Dallillo	permit. Pag Department Important: eny injury c		21. Signature of Funeral Service Lice		22. Name and Address	s of Facility Gre Sette Av	eristi.	Justel H	21225
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l Reco	The lay ate has page 2	Completed					24a. Was an autopsy perform	ed? death?	topsy findings available completion of cause of
	clen: ertific ector.	Be (25. Was case referred to medicat examiner?			26. Place of Death	Check only one)	
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DIVISION	a or Atter after dea t Director d in by the	Certification;	3 Suicide 6 Could not to determined	DB Diese of Injury At home for	m, street, factory, office	28	of Location (Str City or Town	eet and Number or Ru State)	ral Route Number,
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	To the To the comp	Me	29b. Signature and title of certifier	mi)	29c. License	number	29	O 4 / 11 / 3	
	5		30. Name and address of person who	completed cause of death (Item 23a) (A) 14300 Call	Type, Print) and fox	lane STE	- # 2	10 Bowie	MD 20713
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DHMH 17 Rev 1/2001

ORIGINAL

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			For State Registrar	State of Ma	ryland		artmen			and M		giene		1 11612	2
			Decedent's Name (First, Middle,	Last)							2. Date of Dea	ith	V	3. Time of Death	
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	Funeral		5. Social Security Number 6	i.Sex 7. Age	(in yrs. la	st birthday) Yrs.	If Under Months		If Under :	Min.	8. Date of Birtl (Month, Day	, Year)		Inthplace (State or Forei Country)	gn
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	yland sow		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. tnside City Limit	
	Mar.	ţ	MD	n/a		Bal	timor	e						1 Nes 2 □ N	10
	or 28	ire	10e. Street and Number				10f. Zip	Code					en of What	Country?	
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Maryland	12 sh h and 7 in m traum		19a. Informant's Name/Relationshi								I Route Numbe				
ė,	Heali Heali Am 2		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Na	ne of		Iver	Spring ate	20c. Loc	ation - City	d 20905 or Town, State	
<u>o</u>	ant of art: If if y or c		1 ⊠Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			metery, crei on Pa				4/10	/07	Ba1	timor	e, Maryland	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or tteme 23e or 28a-f ahow any injury or other traumatic avant, the Madical Examinet must be notified at ance.		21. Signature of Funeral Service Li					and the last of	1		don Par				
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cor	w require been si should I	ete	DIABUTES MELL	1	RTICU						24a. Was	an	24b. Were	autopsy findings availal to completion of cause of	ble
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)	^			HOUSE O	FFIC	ER	F	ZES!	Ø Ø Ø Ø	D1		AP	RIL	6,2007	
	13		30. Name and address of person w	no completed cause of d	leath (Item	23а) (Туре						_	10000	1441	
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			for State Registrar	State of M	arylan		artmen <i>rtificat</i>			Mental Hy	•		
			Hegistrar Decedent's Name (First, Middle, I	Last)			Timoat			2. Date of De	Reg. No.	2007	3. Time of Death
	Physici /Medic		Raymo		Fr	y, Sr	•			Month April	Day 10,	2007	2:00 A ^M
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	Funeral			. Sex		last birthday) Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	(Month, Da	rth ay, Yea <i>r)</i>	Cou	place (State or Foreign
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	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
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	ems er mi	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Dece	dent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or Note Rican, etc.)	0- 1	 Race - Ameri Black, White, 	
9	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes	2 ∑ No	Specify:			Specify: Wh	ite
3-003p	hour tural' al Ex		15. Decedent's	Year or Dates:	196		dent's Usu	al Occur	ation			d of Business/Ir	
Ċ	in 72 "na" r	Set	(Specify only highest	grade completed)	- \	(Give	kind of wo	rk done	during most of wo	rking		ed Stat	•
7	with jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Lieut	enant	: Col	lonel		Mari	ne Corp	S
0	il Hyg other	BeC	17. Father's Name (First, Middle, La	ist)					18. Mother's Nar	ne (First, Middle	, Maiden S	Surname)	
yland	Aenta Aenta rked tic ev	To E	Edward Arthur F	ry					Marie	Castleb	erry		
Mar	and hard		19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address	(Street	and Number or R	ural Route Numb	ber, City or	Town, State, Zi	p Code)
≥	and and in 27 in 27 iner tra			Vife					Avenue, N3				
ore	Jes 1 of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	☐Removal from State	20b. F	Place of Dispo cemetery, cre	osition (Name matory or o	me of other plac	e) Apr	Date		ation - City or T	
Ě	Pag Iment Iant:		4 ☐ Donation 5 ☐ Other (Spe	cify)	Mon	tgomery			1 2	007		-	Maryland
Баншог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Co	Langust	M013	05 R	2 Name a bert A 557 Wis	nd Addre N. Pun Sconsi	ss of Facility uphrey Fund in Avenue,	eral Home, Bethesda,	Bethe Maryl	sda-Chavy and 20814	Chase, Inc.
П			23a. Part1. Enter the disease, or co shock, of heart failure. List or	omplications that cause	d the deat								Approximate Interval Between
ا ي	Physician		Immediate Cause (Final disease or condition			Larynx							Onset and Death
	/Medical		resulting in death)	Due to (or as									
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۰	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):							
	and and II-tran	хап	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):							
68/60 ,	death certificate be executed a attending physician and d for use as the burial-transit	_		ď									
200	fficate g phys	edic		d									
X D	n cert anding use a	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75-4:-				2	3d. Date of deliv	very
_	death	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a 9□Unknown			⊒Ectopic p ⊒Other <i>(s)</i>		/	 		Month	Day Year
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<u>v</u>	law requires that the de as been signed by the a 2 should be detached	b	Part II. Other significant condition	s contributing to death b	out not res	ulting in the u	inderlying o	ause giv	en in Part I.				the cause of death?
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7	sician : The law certificate has t irector, page 2 s										ormed? 2 X No	death? 1 ☐ Yes	2 □ No
VII	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		15D/0 4	200	Oth	er:			-	
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UNISION	al or Attending s after death. I Director: After d in by the fune	ifica	3 Suicide 6 Could no 4 Homicide determin		jury - At ho	ome, farm, st	reet, factor	y, office					ral Route Number,
5	s afte	Certification:	4 [] Hornicide	building, e	ic. (Specii	<i>y)</i>				City or 16	own, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (Physician: To the best caminer: On the basis of and manner si	of examina								
	o the	Mec	29b. Signature and title of certifier	and manner si	lated.		29	c. Licens	e number		29d. Date	signed (Month	, Day, Year)
	- S - O		Cynthis Y	n Milles	mo	DO		HOC	758037	2	4-1	0-07	
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	107		Cynthia M. Will				aster	Mi.	Ll Road,	Rockv11	le, M	faryland	1 20855
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ature	10.00						
	Regist	ar	ann A a ann A										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9, 3:25 A^{M} April 2007 Violet Foor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Health Services Rossville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar. 19, 1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Months 78 Maryland Director 214 26 5004 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State other traumatic event, the Madical Examiner must be nutified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 USA 37 Gyro Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 \(\overline{\chi}\) \(\overline{\chi}\) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 2 should be fit and Mental H Margaret Musgrove Harry Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is m any injury or other traum once. Rawn I. Foor Husband 37 Gyro Drive Middl River Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem Gardens April 12,2007 Baltimore County Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Sigr ure of Funeral Service License 1407 Old Eastern Avenue Essex Maryland 21221 nt . Enter the disease, or co ook, or heart failure. List of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fly one cause on each line. Approximate interval Between Onset and Death shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Dechin 1/20 **Physician** Lacashr /Medical Due to (or as a consequence of): Examiner Dralyn Stypied Unal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Due to (or as a consequence of) that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Honknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Right marte com Comce 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

CWA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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DHMH 17 Rev 1/2001

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MD

, 821 32. Registrar's Signature 29c. License number

D 31464

29d. Date signed (Month, Dey, Year)

4/10/07

N. EUTAW ST Smte 308 BALTIMORE MI) 2124

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year reent 21 10 200 /Medical mulyn 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4cl County of Death 2 914 Doaman If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🗗 Hours Yrs 212-50-076 Director mar May Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits · 28a-f show notified at 1 PYes 2 No Directo md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 121 ovar man Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 1/0 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) r than " o ca Elementary/Secondary (0-12) College (1-4or 5+) Secretar 1199 12-th 7 is marked other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Res Baeto, mdi Department of Health Important: If item 27 i Boarman 21215 -mothe Are atherine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specific) Important: if ii any injury or o Woodlas -14-07 21. Signature of Funeral Service Lice 70 Pinaich Funual 23a. Pal 1. Inter the disease, or complications that caused the death. Do not enter the mile of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line. Heme Bulto, ind, 21219 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami physician and is the burial-trans Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 Probably 4 √ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 Yes 2 No Division or Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 40 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 - Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death. filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Destritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 UB 32 Registrar's Signature 31. Date filed (Month, Day, Year. State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20 ern. GANTT Month Day **Physician** AI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE OAK CREST VILLAGE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Min. Country 1፟፟፟M 2□F Yrs. 85 MARYLAND Director 219-05-8117 29 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1XXYes 2 □ No Directo MARYLAND N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Introductant: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 1 any Injury or other traumatic event, the Medical Examiner must be 1 once. 1001 ST. PAUL ST. UNIT D-7 21202 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Xes 2 □ No If Yes, Give Year or Dates: 4 2 − 4 6 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION TEACHER 12yrs 4yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ရ GLADYS DAVIS WALTER GANTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2407 W. Mosher St., Baltimore, Maryland 21217 Gradys Dye/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 04-12-07 4 □ Donation 5 □ Other (Specify) GARRISON FOREST OWINGS MILLS, MARYLAND e of Funeral Service Licens 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE rt1. Enter the disease, or co shock, or heart failure. List on callons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mmediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performe ankinjoh deseas 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA P After this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident D rector 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 5+1 Name and address of person who completed cause of death (Item 23a) (Type, Print) Burnen Than ill' 8800 BAULE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR12

2007

32. Registrar's Signature

the ettending physicien end hed for use es the buriel-trensit Box 68760. been signed by the ette should be deteched for Division of Vital Records, P.O. or Attending Physician: efter deeth. Director: After this certifice funeral director. Hospital

Physician

/Medical

Examiner

Director

Funeral

2

Completed

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Certification: To

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Funeral

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them 27 is marked other than "natural", or items 23s or 28s-f shot other traumetic event, the Medical Examinar must be notified as

permit. Peges 1 end 2 should be filed withi.
Depertment of Heelth end Mental Hygiene.
Important: if item 27 is marked other than any injury or other treasment.

3altimore, Maryland 21215-0036

Physician /Medical Examiner To the Hospital within 24 hours e To the Funeral I

State

Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPP HYPERTENSION DIABETES MELLITUS 25. Was case referred to medical examiner? 27. Manner of Deeth 29a. Certifier (Check only one)

RES OOI

SOUTH HANOVER STREET, BALTIMORE MD 2:225

APRIL 10 2007

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

PATEL

APR 1 2 2007

31. Date filed (Month, Day, Year)

3001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 28a, c per md, g866, 04/12/07dhb. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) HEWINS **Physician** DOROTHY 05 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNAPOLIS, MA ARUNDEL MEDICAL CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 ☐ M 2 💢 F 196-18-5803 Jan 6, 1924 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: if item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the M. dical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No Director Maryland | Anne Arundel Deale 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20751 5943 Flood Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1944 If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Saltimore, Maryland 21215-0036 Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Edna Naylor Charles A. Crone 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5943 Flood Avenue Deale, Maryland 20751 John S. Hewins, Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: if it any injury or c Metro Crematory Inc.: 04/06/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee

Thomas Gregor ^{22, Name and Address of Facility} Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Mary Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRACRANJAC ANEWRYSM **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it are all conditions, it are all cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by IYPERTENSION 3 Probably 4 □Unknown 1 Yes page 2 should CHRONIC ATRIAL FIBRICLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Hospital or Attending Physician: 25. Was case referred to medical examiner?

1X Yes 2 No 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient ➤ ER/Outpatient 3 ☐ DOA Certification: To After this Manner of Death 28a. Date of Injury (Morth, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 05/2007 2 Accident within 24 hours after death To the Funeral Director: flace of jury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year) APR 1 2 2007

30. Name and address of

2002

MEDICAL 32. Registrar's Signature

PARKWAY

on who completed cause of leath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Mai	ryland		artmen <i>tificat</i>				ental Hy	giene Reg. No	4 U U	7	11619
	Dhuaisi		1. Decedent's Name (First, Middle,	Last)								2. Date of D Month	eath Da		Year	3. Time of Death
	Physicia /Medic	_		Fl	oren	ce Ag	nes H	all				April			1 901	7:15 A ^M
	Examin		4a. Facility Name (If not institution, g	give street and n	umber)			4b. City,	Town, or	Location	of Death		40	. County	of Death	
			Holy Cross Nurs		_					/ille				Monto	gomer	
	Funeral			. Sex 1 □ M 2 🕱 F		(In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D	ay, Year,		Coun	2.
	Director		218-03-5024 Usual Residence of Decedent			93	115.					Oct 1	2, 1	913	Mary	land
	land		10a. State 10b. County			10c. City, 7	Town or Lo	cation							10	Od. Inside City Limits
	Mary f sh	ŏ	MD Howard	1		Sava	ae									1 XYes 2 No
	28a	Director	10e. Street and Number			Dava	90	10f. Zip	Code				10g. Ci	tizen of W	/hat Coun	try?
	death with the Maryland ms 23s or 28s-f show rmust be notified at		8392 Savage-Gui	lford R	oad			207	763				U.S	.A.		
	death	Funeral	11. Marital Status	12. Was De	cedent Ev	er in U.S.	13. V	Vas Deced	lent of His	spanic Or	igin? (Spe	cify Yes or N Rican, etc.)		14. Race	- Americ	
٥	after or Ite		1 Never Married 2 Married		2 X No)	j	Tes, spec I ☐ Yes :		Specify:		nican, etc.)			k, White, e	
215-0036	ours iral',	d by	3 ♥ Widowed 4 □ Divorced	Year or	Dates:			1 1 1 1 1 1	١٩٥ ليورد	эрвспу.				<i>Зрвсп</i> у	Whit	.e
ก็	72 h natu	ompleted	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced (Give	kind of wo	rk done d	urina mos	st of workii	ng	16b. k	(ind of Bu	siness/Inc	lustry
V	han han	d m	Elementary/Secondary (0-12)	College	(1-4or 5+)	' l		DO NOT us	se retired)	J						
N	lied v lygie ther t	O	5 17. Father's Name (First, Middle, La	ct)			Homem	aker		18 Moth	or's Namo	(First, Middle		wn Ho		
/land	ntal hed o	Be	Joseph Henry Fa	,								•	3, 111001		0,	
ج	hould d Me mark matic	2	19a. Informant's Name/Relationship				19h Mailin	a Address	(Street a		ia Ha	1⊥⊥ I Route Numi	her City	or Town	State Zin	Code)
<u> </u>	id 2 s lth ar 27 ls trau			son				•				Laure		•		
ย์	Hea Hea tem S	1	20a. Method of Disposition	5011	·	20b. Plac	e of Dispo	sition (Nan	ne of			ate			City or To	
9	ages ant of it: If i		1 MBurial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe		n State	l _	etery, cren age Ce			1	Anr 1	1, 07	Satz	200	Mars	yland
aitimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Health and H		21. Signature of Funeral-Service Like			Dava	22	Name an	d Addres	s of Facili	ity			age,	Mary	rand
ñ	Deparent Important Importa		VI SHIFTEN	M		M007	73 D	onald	lson	Fune	ral H	Home, I	P.A.	viano	1 207	υ7-4389
			23a. Part1. Enter the pseude, or co shock, or head silve. List or	emplications that	caused th									yranc	207	Approximate
	Physician		Immediate Cause (Final	lly one cause on	each line	1										Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to	o (or as a	consequer		mel	1110	1					-	
	Examiner			b												
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a	consequar	ice of).									
1	ransi	Examine	Cause (Disease or injury that initiated events	c												
Š	e exe cian a urial-		resulting in death) Last	Due to	o (or as a	consequer	nce of):									
0/20 0/20	cate be executed physician and the burial-transit	dical		d												
Ó X	ertific ding p	413	IF FEMALE:	G2a If year a	utaama af											
X O D	death certifi e attending od for use as	ian/Me	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal de	eath 3	Ectopic pr						23d. Date Mor	e of delive nth	ry Day Year
o.	the de	Physic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9□ Unk		me of deat	n or	Other (sp	өспу)							
7.	law requires that the death certificate been signed by the attending parties as should be detached for use as		Part II. Other significant condition	s contributing to	death but	not resulting	ng in the ur	nderlying c	ause give	n in Part	l.	23e. Did	tobacco	use contr	ibute to th	e cause of death?
S D	uires I sign Id be	d by										1 🗆	Yes 2	. □ No	3 🔲 Prob	ably 4 🖄 Unknown
Ö	w req beer shou	ompleted										24a. Wa	s an	24h V	Vere autor	psy findings available
Hecords	sician: The law s certificate has b lirector, page 2 s	m										auto	opsy ormed?	p	rior to cor leath?	npletion of cause of
_	n: Ti ficate or, pa	e Co	25. Was case referred to medical							aa Die	4 D	1 Yes	2 N	0 1	□Yes	2D No
>	Physician: this certific ral director,	o B	examiner?	Hospital:	Inpatient	2 T FB	VOutpatien	t 3□ DC	Othe		7.7	(Check only ne 5 ☐ Res		6 □Oth	or (Specifi	()
		-	27. Manner of Death	28a. Date	e of Injury	28	Bb. Time of		8c. Injury	at		28d. Describe				,
0	nding ath. r: Afte e fun	atlo	1XNatural 5 ☐ Pending 2 ☐ Accident investiga		nth, Day	rear)	Injury	М	Work	? ∕es 2 🗆	No					
Vision	Atte	ifica	3 Suicide 6 Could no 4 Homicide determin	ad 289. Plac	e of Injur		e, farm, str	eet, factory	, office		2	28f. Location City or To			er or Rura	l Route Number,
5	s after all Dir	Certification;	4 🗆 Nomicide	Dull	uirig, etc.	(Зрвспу)					ļ	Only of 10	own, Stat	9)		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 12 Certifying (Check only one) 2 Medical Ex	Physician: To the aminer: On the and ma	ne best of basis of e nner state	xamination	edge, death n and/or inv	occurred restigation	at the tim , in my op	e, date ar pinion, dea	nd place, a ath occurre	and due to the	cause(s , date an	s) and ma d place, a	nner as st and due to	ated. the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier					290	. License	number				-		Day, Year)
			050					5	00 C	545	.66		41	10/0	7	
	12		30. Name and address of person wi	no completed car	use of dea	ath (Item 2	За) (Туре,	Print)								
	17		Surida Blioga	ülli, 14	702	Chor	ry L	eaf	Tei	va Co	, Si	ven	Spri	ng,	40	20906
	Sta Registr		Surviva Bloga 31. Date filed (Month, Day, Year) APR 1 2	2007	Registrar	's Signatur	A	and i						, -		

			1 - State Registrar			Cert	ificate	of De	eath	F	leg. No.	07	11620
ts.	Physici	an	1. Decedent's Name (First, Middle, La							2. Date of Dea Month	Dav	Year	3. Time of Death
	/Medic		CHARLOTTE E	. BALL						April	7, 20	07	11:15 A M
j_i^{-}	Examin	er	4a. Facility Name (If not institution, give						cation of Death			y of Death	
			Greater Laurel Re			interior i	Laur		Under Of Use	10.5			eorge's
	Funeral Director		, , , , , , , , , , , , , , , , , , , ,	I M 2 TYF	(In yrs. last b	Yrs.			Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug 11	', Year)	Cou	place (State or Foreign intry) orado
	and and		10a. State 10b. County		10c. City, Tox	wn or Loca	ation						10d. Inside City Limits
	Maryl f sho	<u>.</u>	MD Prince	Coorgo	Laure	1							1 □Yes 2 X No
	the 28a-	Director	10e. Street and Number	George	Laure	Τ	10f. Zip Co	ode			10g. Citizen of	What Cou	intry?
	3a or		9000 Briarcroft I	ane #137			2070	R			U.S.A.		,
	ms 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W			nic Origin? (Sp	ecify Yes or No- Rican, etc.)		ce - Ameri	can Indian,
Baltimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show unatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0		Yes, specify □Yes 2🏽			Rican, etc.)	Speci	rick, White, fy: Wh:	, etc. ite
Ö	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation	168		ent's Usual C		n ng most of work	dina I	16b. Kind of E	Business/Ir	ndustry
2	thin 7 le. lan "r Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. Do	O NOT use i	retired)	ig most of work	arig			
2	ed wi ygien ier th t, the	ပ္ပ	7		H	omema	aker				Own H		
2	tal H d oth	Be	17. Father's Name (First, Middle, Last	•				- 1		e (First, Middle,		,	
<u>X</u>	should I	၉	Charles H. Mattic							Izora Bi			
<u>a</u>	2 sh and is m		19a. Informant's Name/Relationship	Type. Print)	19	b. Mailing	Address (S	treet and	Number or Rui	ral Route Numbe	r, City or Town	, State, Zi	p Code)
<u>~</u>	and lealth m 27 her tr		Michael Lewallen	/grandson						08, APO			
ore e	Pages 1 nent of H ant: If Ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place cemet	of Disposi ery, crema	tion (Name atory or othe	of er place)	1	Date	20c. Location	- City or T	own, State
Ē	. Pa tmen tant: jury		4 □ Donation 5 □ Other (Speci		Maryl		Vet. (_			ville	, Maryland
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Lies	nsee /	M0077	3 31	Name and A Dnalds L3 Tal	Address of on F bott	fFacility uneral Ave. L	Home, P. aurel, N	.A. Marylan	d 207	707-4389
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	the death. Do	not enter	the mode	of dying, s	uch as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician	W Y	Immediate Cause (Final disease or condition	Sepsis								- 1	Onset and Death
1	/Medical		resulting in death)	Due to (or as a	consequence	e of):		-					
Ġ.	Examiner -		Sequentially list conditions	b. Acute re			re						
7	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Ends Uncerving Cause (Disease or injury	Due to (or as a	consequence	e of):							
V	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Aspirat			nia						
68760,	icate be executed physician and s the burial-transit		resulting in death, Last	Due to (or as a	consequence	e of):							
87	cate to	Medical		▲d				·					
	sertifica ding pl		IF FEMALE:	23c. If yes, outcome p	f pregnancy							-	
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal deat	th 3 □E 5 □ 0	Ectopic preg Other (speci					ate of deliv onth	very Day Year
<u>a</u>	that ned by deta		Part II. Other significant conditions	contributing to death but	not resulting	in the und	lerlying caus	se given ir	Part I.	23e. Did to	bacco use cor	tribute to	the cause of death?
rds	quires n sign ald be	d by	Bilateral pneumo	nia						1 □ Y	es 2⊉No	3 ☐ Pro	bably 4 □Unknown
Vital Records,	e law rec has beer e 2 shou	Completed	Anaphylaxis							24a. Was a	in 24b.	Were auto	opsy findings available ompletion of cause of
<u>=</u>	sician: The law s certificate has t irector, page 2 s		Atherosclerotic	cardiovasc	ular d	iseas	e			perfor 1□ Yes	med? 2 X No	death?	2□No
Ĕ	iciar certif ector	Be	25. Was case referred to medical examiner?	Hospital:				O41		h (Check only or			
or	Phys this	P.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury	t 2 ER/O	Outpatient Time of			4 X Nursing Ho	ome 5 Residence 128d. Describe he			ify)
n C	ding J. After funer	io	1 X Natural 5 ☐ Pending	(Month, Day	Year)	Injury	М 200.	Injury at Work?	2∐No	Zou. Describe in	ow injury occu	rreu	
Division or	death ctor: y the	icat	3 Suicide 6 Could not b		v · At home, f	farm. stree			20140	28f Location (S	treet and Num	her or Rur	al Route Number,
2	after Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	,	,,			City or Town		DOT OF THAT	ar rioute rumber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical C	(Check only 2 Medical Exa	nysician: To the best of miner: On the basis of	examination a	ge, death o	occurred at a	the time, o	date and place, on, death occur	and due to the c	ause(s) and m	anner as	stated.
	thin 2.	Medi	29b. Signature and title of certifier	and manner state	ed.			icense nu					
	7 × × 8		A A A I	a Dala	Λ ~	/	1	7	967	2 1	29d. Date signe		
,	0	-	- Wasii	& NOW	NO) (T. =		1	110		April	TO, 2	2007
	3		30. Name and address of person who	·				330	Laurol	, Maryla	nd 207	0.7	
	Sta	te	Maria Dobyns, M. 31. Date filed (Month, Day, Year)	271	van Dus r's Signature		wau #	JZU,	тайтет	, Maryia	111G ZU/	0 /	
	Registr		5DD 1 9 2007	Flant	de do	Carlo de	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end items 4a, 10e, f per doc 8866 4-12-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** 2007 12:00 AM Mae Heck March 28. /Medical 4a. Facility Name (If not institution, give street and number)

Abby Manor Chestnut

2017 Montclair Drive 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Howard 8. Date of Birth (Month, Day, Year) 4, 1912 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 五 P 95 Director 143-05-4861 New Jersey Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "neturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Howard Ellicott City 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code St. 21043 2817 Montclair Drive USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White Completed should be filed within 72 hc and Mental Hygiene. smarked other than "netur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Farrite Laminating Elementary/Secondary (0-12) College (1-4or 5+) Corporation 12 Machine Accounting treumetic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; if item 27 is marked oths any injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Zofia Pliska Frank Monash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4704 River Road, Bethesda, MD Richard Monash/Nephew 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Peters 3/ Cementery 22. Name and Address of Facility 3/31/07 1 4 ☐ Donation 5 ☐ Other (Specify) Garfield, NJ 21. Signature Funeral Service Licensee Kamienski Funeral Homes, Inc. Garfield, NJ 233 Part 1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of) **Examiner** Coronary Heart Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine burial-transit ре ехе Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) detached ☐ Yes 2 X No P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ should be Dementia 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy rmed? 2⊠ No certificate 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ${}_4\square$ Nursing Home ${}_5\square$ Residence ${}_6\boxtimes$ Other (Specify) ${}_4$ Asst. Injury at 28d. Describe how injury occurred ${}_4\square$ Unit Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No 70 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After 1 DO Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) nd_title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Dav. Year) D0063145 3-28-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arvind D. Desai, M.D. 115 Roesler Road, Glen Burnie, MD 21060

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

State

Registrar

2 2007

APRIL 8, 2007 6:30 p.m. Baltimore, Maryland 21215-0036

Physici /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical

ELIZABETH HERBERT

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

For State Registrar	State of M	/laryland / [•	cate of L		and iv	iemai	riygic	110		
Registrar Decedent's Name (First, Middle, Last)			Certini	cate of L	Jeain		2 Data	Reg of Death	. No.?	97	3. Time of Death
							Mont	th	Day	Year	
ELIZABETH J. H							Apri	.1		007	6:30 p
a. Facility Name (If not institution, give s		,		City, Town, or		of Death				ty of Death	
STELLA MARIS-DU				L'IMONIU Inder 1 Year	M If Under	24 Um	0 D-1-	-(D'-II	BALT	IMORE	
1	M 2XX	Age (In yrs. last bir		nths Days	Hours	Min.	8. Date (Mon	th, Day, Y	ear)	Cou	nplace (State or Fore untry)
107-14-8603		95					MAY	11,	1911	IVIZ	ARYLAND
0a. State 10b. County		10c. City, Town	n or Location	1							10d. Inside City Lim
MARYLAND HARFOR	0.00		JOPPA	Δ							1 □ Yes 2 X
Oe. Street and Number	0 00			f. Zip Code				100	. Citizen of	What Cou	untry?
14 BRIDGE DRIVE				2108	5				U.S.	Δ	•
	12. Was Deceder	nt Ever in U.S.	13. Was [Decedent of Hi		ain? (Spe	ecify Yes	or No-			ican Indian.
1XXNever Married 2 Married	Armed Forces 1 ☐ Yes 2X	s?	If Yes	, specify Cuba	n, Mexicar	i, Puerto	Rican, et	c.)	Bla	ack, White	e, etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	_	1 □ Y	es 2KNo	Specify:				Spec	ify: BLA	ACK
15. Decedent's Educ	cation	16a.	. Decedent's	Usual Occupa	ation			16	b. Kind of I	Business/I	ndustry
(Specify only highest grade	e completed)		(Give kind of life. DO N	of work done o OT use retired	luring mos)	t of worki	ing			IMORI	•
Elementary/Secondary (0-12) 5th grade	College (1-4o		EAMSTE	RIST				l c			COLLEGE
7. Father's Name (First, Middle, Last)					18. Mothe	er's Name	e (First, A		iden Surna		
JERMIAH JONES					Т.7	ZIIRZ	BROV	۷N			
19a. Informant's Name/Relationship (Ty)	pe. Print)	19h	. Mailing Ad	dress (Street a					City or Town	n. State 7	(ip Code)
Sedonia Johnson/Co	,		-	dge Dr.					-		
Oa. Method of Disposition	USIII	20b. Place of			; 501		Date				Town, State
1 ⊠Burial 2 □ Cremation 3 □ R	emoval from Stat	comete	ry, cremator	y or other plac	í					-	
4 □ Donation 5 □ Other (Specify)	1	ASBUR	Y U.M.	.C.	()4-13	3-07	W	HITE	MARSI	H, MARYLAN
21. Signature of Funeral ervice Licens	9è //										
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Marie Hall 2:20 AM 2007 /Medical QC. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Severa If Under 24 Hrs. If Under 1 Year Months Days 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1□ M 2□ F Days Hours Min Maryland Director 82 Oct 6, 1924 218-15-1503 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the M. dical Examiner must be notified at 1 Yes 2 No Director **Baltimore** N/A Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21223 400 Millington Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Black þ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mentat Hygiene. 7 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Ross Joseph Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is 2720 Claybrook Drive Baltimore, Maryland 21244 Kelly Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Baltimore, Md. 04/10/07 4 Donation 5 ☐ Other (Specify) Western Star Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 23 201010 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 9 the 38 attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown Completed 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hast autopsy page , certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2D/No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Inpatient 2 2 ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 1

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU / Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** March 30, 2007 12:19AM Roger D. Hailey Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Shady Grove Adventist Nursing Home 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
September 19,1928 North Dakota If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days Hours 1 ★M 2 ☐ F 501-20-0218 78 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☑ Yes 2 ☐ No Directo Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code United States 20878 810 Crystal Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 1947 – If Yes, Give Year or Dates: 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Radar Man Navy 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Johnson Moses Franklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15021 Turkey Foot Road, Darnestown, Maryland 20878 Abell /Step-daughter G. Joan. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 17, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Arlington, Virginia 2007 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee Suggestle M01305 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardio Vascular Disease 6 Months Due to (or as a consequence of): Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure 1 | Yes 2 | No 3 | Probably 4 \ Unknown Lung Abscess 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner certificate be executed burial-transit and Box 68760, physician s the burial Physician/Medical as use ed by the a P.O. signed by t or Vital Records, 2 Completed has page 2 Be ٩ this Division

Funeral

Director

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"naturai", or items 23a or

death

filed within 72 hours after

nit. Pages 1 and 2 should be filed within 72 h artment of Health and Mental Hygiene. ortant: If them 27 is marked other than "natu Injury or other traumatic event, the Medical

Department or important: if any Injury or

Physician

/Medical

Examiner

Maryland 21215-0036

Baltimore,

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: Medical

X

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8609 Second Avenue, #404B, Silver Spring, Maryland 20910-3374 Ravi Passi, M.D. 31. Date filed (Month, Day, Year) APR 1 2

determined

4 Homicide

(Check only one)

atore and title of certifier

29a. Certifier

29b. Sign

32. Segistrar's Signature

1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D28656

29d. Date signed (Month, Day, Year)

April 2, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 0350A 50 OY 4c. County of Death WICOMICO 9. Birthplace (State or Foreign

1. Decedent's Name (First, Middle, Last) Physician /Medical Eacility Name (If not institution, give street and number Examiner 8. Date of Birth (Month, Day, Y Sept 24, **Funeral** Months Days 1**X** M 2□ F Hours 335-50-1888 51 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the M. dical Examiner must be notified at Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 401 Liberty Street Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. landscaper permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, the unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pat Huntsman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Huntsman/son 401 Liberty Street Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signatura Funeral Struice Licensee Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part1. Anter the disease or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Medical Due to (or as a consequence of): ∉xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760 physician Physician/Medical the as attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed peen 24a. Was an page 2 certificate Division or Vital Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient 2 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Magner of Death 28c. Injury at Work? To the Hospitar c. within 24 hours after death.

To the Funeral Director: Aft

---letely filled in by the fur Hospital or Attending Natural

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

29b. Signature and title of certifie

29c. License number 026278

29d. Date signed (Month, Day, Year)

Illinois

USA

Black, White, etc.

Specify: White

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☑ No

un

address of person who completed cause of death (Item 23a) (Type, Print)

2007

PO BOX 1733 ocker 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** <u>April</u> 2007 07:00 Mildred B. Ihrie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Catonsville</u> Forest Haven Nursing Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 ☐ M 2 🔀 F 88 June 22, 220-05-7839 1918 Pennnsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ▼ No Director MD Baltimore Arbutus 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1238 Francis Avenue 21227 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Health and Beauty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Lineburg Edith Williams ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leon L. Lineburg 1238 Francis Avenue Arbutus MD 21227 20b. Place of Disposition (Name of cametery frematory or other place)
Loudon Park Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 XBurial 2 ☐Cremation 3 ☐Removal from State 4-11-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service icensee

Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus Md 21227
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final) pproximate Interval Between Onset and Death THEROSCLEROTIL Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed g physician and as the burial-trans that initiated events Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical as attending plant lifer use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performe this certificate 1□ Yes 2 1 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 ER/Outpatient 3 DOA 1 🗌 Yes 20 No 1 | Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Certification: After (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type) Print) RETENSPRING ATE, SUITE 2835 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	ite of Maryland		tificat				JIE∏E leg. No. ⊜	7 0 7	116	20
П	<i>\$</i> 4	06	Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time of De	eath
*	Physicia /Medic		ESSIE JONES						April		2007	5:10	\mathbf{A}^{M}
,	Examin	100	4a. Facility Name (If not institution, give street	and number)		4b. City,	Town, or L	ocation of Death		4c. Coun	ty of Death		
No.			Washington Adventist	-				a Park			tgome		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. In	ast birthday). Yrs.	Months	Days	Hours Min.	8. Date of Birtl (Month, Day May 27,	, Year)	Coun	lace <i>(State or F</i> etry) essee	roreign
25	D		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation					1	0d. Inside City I	1 imits
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	the 28a-	Director	10e. Street and Number	51	TAGE .	10f. Zip				10g. Citizen of	f What Coun	itry?	
	3a or		1000 Daleview Drive				2090)1		USA			
	death ms 2 r mus	Funeral	11. Marital Status 12. Wa	as Decedent Ever in U.S	S. 13. \	Was Dece	lent of His	panic Origin? (Sp. , Mexican, Puerto	ecify Yes or No-	14. Ra	ace - Americ ack, White,		
36	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 1	The direction of the control of the		i Tes, spe 1 □ Yes		Specify:	riioari, cic.	Spec	ihe	nite	
5-0036	72 hou natura ical E		15. Decedent's Education (Specify only highest grade comp	nleted)	16a. Deced	dent's Usua	l Occupa	tion uring most of work	ina	16b. Kind of	Business/Ind	dustry	
121	vithin ine.	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5+)		cticu		uring most of work		ATazzo	a o w		
2	filed v Hygie other t		12th 17. Father's Name (First, Middle, Last)	<u> </u>	пол	LLICU		18. Mother's Name	e (First, Middle,		sery ame)		
Maryland 2	be d o	To Be	Charlie Kuykendall						ie Reav		,		
ary	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	-8	19a. Informant's Name/Relationship (Type. Pr.	int)	19b. Mailin	ng Address	(Street a	nd Number or Rur	al Route Numbe	er, City or Tow	n, State, Zip	Code)	
	and 2 ealth n 27 i	17	Jean Lanham/Daughter	les p				of Drive,			20707		
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remove		lace of Dispo emetery, cren Carme				2007	20c. Location	ine, M		
Ħ		4	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service of nsee	PIC.				- , , ,	naldson				1
Ř	permit. Departi Importi any inj		Janie Vans	den MOOI				t Avenue			2070		
			28a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death se on each line.	n. Do not ent	er + e mod	of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Betwee Onset and De	en eath
	Physician /Medical	ř	Immediate Cause (Final disease or condition resulting in death)	- LUU	W	ΛW	M	nally	uu	(1)1_	- 1		
	Examiner			Due to (or as a conse	Lence of):	hx	19						
Ŧ	D #	ner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of	0	^	to t	1 /).	1000	/		
V	ficate be executed physician and is the burial-transit	Examiner	that initiated events c	Due to (or as a consequ	Jence of):	W	Ur.	Ulsung		LUI)			
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687	# D 00	edical	- a										
Вох	leath certifi attending I for use as	M/ns	23b. was decedent pregnant	yes, outcome pf pregna □Live birth 2 □ Fetal		∃Ectopic p	ennancy				Date of delive	-	10
	The law requires that the death certi te has been signed by the attending tage 2 should be detached for use a	Physician/M	in the past 12 months?	□Pregnant at time of de□Unknown		Other (s					Month	Day Ye	ar
О.	ires that the signed by be detac		Part II. Other significant conditions contributi	ing to death but not resu	ulting in the u	nderlying o	ause give	n in Part I.	23e. Did to	obacco use co	ntribute to the	he cause of dea	ath?
Vital Records,	w requires been sign should be	ed by							1 🗆 1	∕es 2∑XNo	3 ☐ Prob	oably 4 ∐Un	known
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<u> </u>		Completed							perfo	rmed? 2 X No	death?	2 ∏ No	
Vita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1. To your 257 No. Hospital	al:			Otho	26. Place of Deat					
ō	Phys r this ral dir	-: To	I les ZX No	a. Date of Injury	28b. Time of		28c. Injury Work	4 LI Nursing Ho	ome 5 Residence Residence Residence Property Residence R			fy)	
o	riding th. r: Afte e fune	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		? ′es 2□No					
Division	or Atte fler des irecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 286	e. Place of injury - At ho building, etc. (Specify	ome, farm, str v)	reet, factor	/, office		28f. Location (S City or Tov	Street and Nur vn, State)	mber or Rura	al Route Numbe	er,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it is a completely filled in by the funeral director, it is not the funeral director.		29a. Certifier (Check only ocheck only ocheck only ocheck only ocheck only och och och och och och och och och och	On the basis of examina									
	o the vithin 2 o the omplet	Medical	29b. Signature and title of certifier	nd manner stated.		29	c. License	number	/ -	29d. Date sign	ned (Month),	Day, Year)	
)	F ≤ F ö						<	6/1	171	4	161	07	
		1	30. Name and a dress of person who complete	ted cause of death (Item	23a) (Type,	Print)				1		,	
	1		DR. NASREEN KAN			coll A	venu	e, Takom	a Park,	MD 20	912	-	N
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ilule .	all I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8, 10:45p Mary April 2007 Kreeger L. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carrol1 Long View Nursing Home Manchester 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** 8/18/1926 Days Hours 1 □ M 2 1 F MD. Director 216-20-3293 Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10b. County 10c, City, Town or Location 1 ☐ Yes 21 No Director MD. Carrol1 Manchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with items 23a or Examiner must be 3332 Main Street 21102 U.S.A. death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 10 Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) education Elementary/Secondary (0-12) College (1-4or 5+) 11 school teacher and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Dost Lauterbach Ivel Rose McHarry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 : Department of Health ar Important: If item 27 Is any Injury or other trau. (Daughter) 27193 Pinebrook Terrace, Hebron, Maryland 21830 Mrs. Christine Standon Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Pk 04/12/07 Sykesville, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors Inc 21. Signature of Funeral Service Licenses 8728 Liberty Road, Randallstown, Md. 21133 Lemm 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (has a consequence of): Examiner death certificate be executed burial-trar P.O. Box 68760, Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE JSe S 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2) No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28h Time of ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the cause (s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

APR 12

DHMH 17 Rev 1/2001

ANOVER

2007

32. Resistrar's Signature

Manchester MD. 21102

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of Ma		d / Departme Certifica	ent of H	lealth and	Mental Hy		007	11631
	Physicia /Medic		1. Decedent's Name (First, Middle, La MORTON D. KILE	•					2. Date of De.		20 0 7	3. Time of Death 3:43 A ^M
	Examin		4a. Facility Name (If not institution, giv 4419 ARABY CHU	e street and number) RCH ROAD		_	ty, Town, o	r Location of Dea	th		ounty of Dea	
Ī	Funeral Director		5. Social Security Number 6. S 219-05-9767				der 1 Year			h v. Year)	9. Bir Co	thplace (State or Foreign ountry) rginia
	Maryland	ō	Usual Residence of Decedent 10a. State 10b. County	i oli		r, Town or Location						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Σ T	with the Page or 28a-	Direc	Maryland Freder: 10e. Street and Number	<u> </u>			Zip Code	<i>i</i> .			n of What Co	
5:45 036	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Indeportant: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show eny Injury or other traumatic event, the Medical Examination intellibe incilled at once.	by Funeral	4419 Araby Church 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 No		If Yes, s			Specify Yes or No to Rican, etc.)	- 14.		erican Indian,
/07 3: ¹ 215-0036	ithin 72 ho ne. "netur Nedical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+	-)		work done Tuse retired	eation during most of wo d)	orking		of Business	
4/10/07 and 21215	d be filed w ental Hygier ked other ti c event, the	To Be Co	12 17. Father's Name (First, Middle, Last Lewis E. Kilby, S			Meat Cu	tter		me (First, Middle, Jane Car	Maiden Su	rocery	7
KILBY 4/] re.Marvland	and 2 shou alth and M 127 Is mar er traumati		19a. Informant's Name/Relationship (Betty A. Kilby /			19b. Mailing Addre						
2	Peges 1 6 ment of He ant: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☆ Cremation 3 ☐ 4 ☐ Donation ☐ Other (Special	y)		lace of Disposition (f emetery, crematory of sthaven Cr			11 ^{at} ¶1, 2007			Town, State Maryland
Morton ■ Baltin	permit. Depert Import eny Inj once.		21. Signature of Ferneral Service Lice			9501	Catoc	tin Mtn.	Services Hwy. Fr	ederi	ot Coc ck, Mi	21701
	Physician /Medical Examiner		23a. Part1. Inter the diseave or complete shock, or heart failural list only immediate Cause (Findisease or condition resulting in death) Sequentially list conditions,		ic C	olon Canc		ng, such as cardia	ic or respiratory ai	rest,		Approximate Interval Between Onset and Death 15 months
38760.	s be sicle but	edical Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
P.O. Box 68	The law requires that the death certificate to the best been signed by the attending physicage 2 should be detached for use as the burdens.	Completed by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal	death 3 Ectopic		′		230	d. Date of de Month	ilivery Day Year
rds. P	quires that in signed b	ed by PI	Part II. Other significant conditions of Prostate Cancer	contributing to death but	t not resu	Ilting in the underlyin	g cause giv	en in Part I.				o the cause of death?
Reco	The law requir cete hes been si page 2 should	omplet	Diabetes Recurrent Pneumo	thoray						rmed?	prior to death?	utopsy findings available completion of cause of
ita		BeC	25. Was case referred to medical	CHOLAX		389		26. Place of De	1 ☐ Yes ath (Check only o		1 7 7 8	2 140
>	Physicien: this certificanal director,	20	examiner? 1 ☐ Yes 2 图 No	Hospital: 1 Inpatien	t 2 🗆	ER/Outpatient 3	DOA Oth	er: 4 🗆 Nursing	Home 5⊠Resid	dence 6	☐Other (Spe	ecify)
Division of Vital Records.	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigatio 3 □ Suicide 6 □ Could not b			28b. Time of Injury M		yat k? Yes 2 □ No	28d. Describe I			
Divi	oltel or At urs after o aral Directilled in by		4 Homicide determined	building, etc.	(Specify				City or Tox	vn, State)		lural Route Number,
	Hospitel 24 hours a Funeral l etely filled	Medical	29a. Certifier 1 Certifying Pl	nysicien: To the best of niner: On the basis of e and manner stat	examinai	wledge, death occurr ion and/or investigat	ed at the tir ion, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) ar date and pl	id manner a lace, and du	s stated. e to the cause(s)
	To the To the To the Complete	Me	29b. Signature and title of certifier Morlen	J. Ha	en	n de Sh	29c. Licens	e number 31362			signed (Moni	th, Day, Year)
	571		30. Name and address of person who	(.	/							
	9		Marlene Hammond, 31. Date filed (Month, Day, Year)	M.D. 501 F			, Gai	thersbur	g, MD 20	877		
	Stat Registra		or, Date filed (Mortin, Day, 1981)	Sz. Hegistral	s signa	St. M.						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Cecilia Helen Lackwitz 12:00 PM 2007 Apri] 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carrol1 2310 Todd Lane **Eldersburg** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗑 F 98 Yrs. 1908 Maryland Director 213 05 1170 June 8, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🖾 No Maryland Carrol1 Eldersburg Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2310 Todd Lane U.S.A. 21784 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 3rd 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Watcheski Anna Goetzke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eldersburg, Maryland 21784 Dorothy Wiedner / Daughter 2310 Todd Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if any injury or once. Glen Haven Mem. Park 4/10/2007 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Ritchie Highway Baltimore, Maryland 21225 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Examiner

Physician /Medical Examiner

with the Maryland

death v

within 72 hours after

Pages 1 end 2 should be nent of Health and Mental

t of Health a : if item 27 is

or other

Baltimore, Maryland 21215-0036

28e-f ehov

rthan "natural", or Iteme 23a or 28e-f ehov the Medical Examiner must be notified at

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit the within 24 hours after death.

To the Funerei Director: After this c completely filled in by the funeral dire

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec			Onset and Death
Sequentially list conditions, Tary leading to the collaboration of the c	Due to (or as a consec			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of a	al death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying cause given in Part I.	1 ☐ Yes 24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical			1 Yes 2	No 1 ☐ Yes 2 ☐ No
examiner?	ospital:	04	ath (Check only one)	. Tour 10
27. Manner of Death 1 Natural 5 Pending Accident Investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA Other 4 Nursing	dome 5 Residence 28d. Describe how in	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory, office fy)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29h Signature and title of certifier	sicien. To the best of my knier: On the basis of examinating and manner stated.	owledge, leath occurred at the time, date and placation and or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of contifier	A / /	29c. License number N37944		Date signed (Month, Day, Year) WI 9th 2007
30. Name and address & percent who co	mpleted cause of death (Ite		Sux 6201	, 2457

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 12

32. Registrar's Signar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

udrey M. Lomax		State of Maryland / Depar 1- For State Cert	rtment o		l Mental Hy	-	2007	11633
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	/			Reg. 2. Date of Death		3. Time of Death
ledical Examin	ner	4a. Facility Name (if not institution, give street and number)	10	MAX		Month April 8, 2007		0032 hrs
		4a. Facility Name (if not institution, give street and number) Franklin Square Hospital		4b. City, Town, or L Rosedale	ocation of Death		4c. County of Death Baltimore Cou	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last)	st birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Bir	
Director		212-86-7279 1 m 2 XF 39	Yrs	Months Days		1	Foreig	
	ŀ	Usual Residence of Decedent			<u> </u>	Jane 15,	1967	77110
A any	ſ	· · · · · · · · · · · · · · · · · · ·	Town or Locat					10d. Inside City Limits
Aaryland 28a-f show i at once.	희	$M \cdot D$ $N \cdot A$	BAITI	10f. Zip Code		- Tab	616	1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	irec	10e. Street and Number		10f. Zip Code	110	10g.	Citizen of What Cour	
oith the	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S	13 W	as Decedent of Hisp		ecify Yes or No-	14. Race - Ameri	can Indian, Black,
eath v	nuel	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		es, specify Cuban,			White, etc.	
after c	Ē.	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 No	specify:		Specify B/A	12
hours				nt's Usual Occupation ost of working life.		ed)	6b. Kind of Business/	
36 thin 72 te. than "	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	CILLA	ation 1	66-		MARYLAND	1 Correction
215-0036 be filed within 72 that Hygiene. Red other than ent, the Medical	Completed	17. Father's Name (First, Middle, Last)	00,10	ectional 1	8.Mother's Name	(First, Middle, Mai	iden Surname)	
21215-00 uld be filed wit Mental Hygien marked other	æ	Michael Lomax			COURT	ney £	Pedd . er, City or Town, State	
	ျ	19a. Informant's Name/Relationship (Type, Print)						
두 당분 별 종		Courtney Moody 20a Method of Disposition 20b. Pl	340 9	sition (Name of cem	netery.	<u> ソセ <i>I3</i> 4 /</u> Date	20c. Location - City or). 2/2/>
Baltimore, permit. Pages I ar Department of Hee Important: If ite	- 1	d Name of the Company	rematory or ot	ther place)				
Baltimor permit. Pages Department of Important: If	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22 1	Name and Address	of Facility	4 13,200 7	HRBULL	15. MI)
Balti permit. Departn Import		(Hotsinia Bitt		BeTTS F	CAROL.	105T	BAHO.	m) 21212
Physician	\dashv	23a Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line.	Do not enter	the mode of dying, s	such as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. Pulmonary Thromboemb	iloc					Death
LAdminer		or condition resulting in death) Due to (or as a consequence of) Deep Venous Thrombos						
	P	Sequentially list conditions, if any, leading to immediate b. Deep verious Thioribos Due to (or as a consequence of)						
	miner	cause. Enter Underlying Cause (Disease or injury that initiated				_		1
d ted	Exa	events resulting in death) Last Due to (or as a consequence of)	jî.					
0, be executed sician and burial - transi	edical	UNPENDED AMENDED						
Box 68760, e death certificate be exithe attending physician ed for use as the burial	Med	IF FEMALE: 23c. If yes, outcome of pregn.	ancy				23d. Date of deliver	у
Sox 6876(leath certificate e attending physe for use as the b	اق	23b. Was decedent pregnant in the past 12 months?		etal death 3	Ectopic pregnar	ncy	Month I	Day Year
Box e death the atter	ysici	1 Yes 2 No 9 V Unknown 9 Unknown	2 □ 0	ther (Specify)				
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the l	y Phy	Part II. Other significant conditions contributing to death but not re-	sulting in the	underlying cause gi	iven in Part I.		acco use contribute to	
S, P	ed by			-		1 2222		bably 4 Unknown utopsy findings available
cords, law requir has been s	plet					24a. Was an autopsy perform	prior to	completion of cause of
Rec The la	Completed					1 ✓ Yes 2		es 2 No
Division of Vital Records, tal or Attending Physician: The law requirs after death al Director: After this certificate has been seed in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner? Hospital: 1 Innerticat 2			of Death (Check of Other)		esidence 6 Othe	
of Viting Physic After this c	٩	1 V Yes 2 No	ER/Outpatien 28b. Time of	11 3 DOX	y at Work?	28d. Describe ho		1.
ion of \ tending Phy eath tor: After th the funeral	ertification:	1 V Natural 5 Pending (Month, Day, Year)		1 Y	es 2 No			
/iSic	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At ho	me, farm, stre	eet, factory, office be	uilding, etc.	28f. Location (Str or Town, Sta		ural Route Number, City
Divipital or ours after the filled in	Certi	4 Homicide determined (Specify)				or rown, sta		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledg one) Wedical Examiner: On the basis of examination an	je, death occu	urred at the time, da	ite and place, and	due to the cause(s) and manner as sta	ed equise(s)
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination an and manner stated. 29b. Signature and title of certifier	na/or investiga	29c. License			29d. Date signed (Mo	
	2	290. Signature and title of certifies) di	O.C.N			April 8, 2007	, 24,, ,
		30. Name and address of person who completed cause of death (Item	23a)					
Z				Street, Baltimo	ore, MD 2120	1		
	ate		re	-				
Regist		APR 1 2 2007	-					
DHMH 17 Rev 1/20	001		ORIGIN/	AL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:22 PM MARTISE 2007 JAMIE 05 april /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City. The Johns Hoplans Hospital If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 214-57-3943 Months Days Hours Yrs. Director Cantina North June Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 Ses 2 No Funeral Director ma 10e. Street and Number 10g. Citizen of What Country? 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubay, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify: 3 Widowed 4 Deivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 le marked other then "na eny injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) rucking 24 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be moore ULTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Manor - Friend MD, 2/136 an 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State -0 Ceneter 4 ☐ Donation /5/☐ Other (Specify) 21. Signature of Puneral Service Licensee Name and Address of acility Balto, md, 21224 ttome 23a. Pain. Enter the disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, shock/or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pulmonary embolism

Due to (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** metastatic 25 days lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760; IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Deat Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter 1 Natural 5 Pendina I Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by filled in by 4 Homicide Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) tle of certifier 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year) Medical Doctor Res-000 April 05 2007

pleted cause of death (Item 23a (Type, Print)

The Johns Hopkins Hospital, 600 North Wolfe Street, Maryland 21287

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 200^{Year} APRIL 10 DOROTHY ANNA MCGONIGLE 4:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days NEW YORK 1 ☐ M 2 🛛 F 126-16-8411 79 Director 1927 AUG. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ms 23a or 28a-f short must be notified at 1 ☐ Yes 2 ☑ No Directo NY Suffolk Riverhead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11901 1661 Old Country Road #6 Funeral U.S.A. "natural", or items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3KD Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Key Punch Operator Cosmetics traumatic event, the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ELSIE MIXAN ERNEST PANNASCH ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Thompson 261 Parkway Dr. Calverton, NY If Item 27 (Daughter) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö Department of Important; If any injury or once. 4-14-07 Farmingdale, NY Charles Cemetery 22. Name and Address of Facility
CLAYTON FUNERAL HOME INC
25 MEADOW RD., KINGS PARK, NY 11754 21. Sign dure of Funeral Service Lightney V-lamen ennes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause out ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2X No death? 1 ☐ Yes 2 □ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 🕅 Inpatient 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 28c. Injury at Work? after death.

I Director: After do in by the funera After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled i Hospita 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of co 29d. Date signed (Month, Day, Year) APRIL 11, 2007 MDD62471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

APR 1 2 2007

GHULAM ABBAS, MD



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 29d per doc 8866 4-12-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 17 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2007 2:05 PM Rankin Merchant March 10, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Somerford Place Anne Arundel Annapolis Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 91 Fe. 18, 1916 Director 577-01-2418 Kentucky Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rat, or iteme 23a or 28a-f show Examiner must be notified at MD 1 ☐ Yes 2 No Anne Arundel Edgewater Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1543 Brice Circle 21037 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZY No If Yes, Give Year or Dates: 14 Bace - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Depertment of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other treumatic svent, the Martine and Once. Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Completed by White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supply Clerk US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John S. Hutchison Leila Rankin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1543 Brice Circle Edvewater, MD 21037 Mary L. Harrell (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 3-17-07 Leesburg, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Colonial Funeral Home Nen 201 Fdwards Ferry Rd. NE Jeesburg, VA 20176 Arri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtly, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced Dementia Physician disease or condition resulting in death) 6 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of as the burial-transit Due to (or as a consequence of): attending physicien by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🎇 No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy oerformed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Asst Livin 1 Yes 2 No ٩ filled in by the funeral 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 14 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 1246360 APRILIZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

ICHASE 31. Date filed (Month, Day, Year)

Ann 1

2

with the Maryland

altimore, Maryland 21215-0036

The law requires that the death certificate be execu

To the Hospital or Attending Physician:

death

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes or a

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H		_	giene ()	7 1637
			Decedent's Name (First, Middle, Last	it)				2. Date of De	ath	3. Time of Death
	Physici /Medic			Fanni	e Mae	Mallor	V	Month 4	Day Yea 5 2007	0.20 -11
	Examin		4a. Facility Name (If not institution, give		- 1146		or Location of Deat	-	4c. County of De	
			913 Pennsylvar	nia Aven	ue Apt	Baltim	ore		NA	
ls.	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 9 F	Birthplace (State or Foreign Country)
ŧ.	Director		239-38-14/1	LIM ZLANF	78 Yrs.	24,5	1100.0	1-1-		N.C.
	w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryla F sho	ō		37.3						1 ☐Yes 2 ☐ No
	the N 28a-	rect	MD 10e. Street and Number	NA	Baltimo	10f. Zip Code			10g. Citizen of What	Country?
	with Ba or t be	Ö	913 Pennsylvani	a Avenue	Apt 1 C	21201			L. L. II	ooundy.
	ns 2: mus	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	Specify Yes or No	U S A 14. Race - Ar	nerican Indian,
9	after or itel	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X N If Yes, Give	lo	f Yes, specify Cub		to Rican, etc.)	Black, Wi	
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	lent's Usual Occup kind of work done	during most of wor	rking	16b. Kind of Busines	ss/Industry NA
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	iled v Hygie ther t	ပ္	12th grade 17. Father's Name (<i>First, Middle, Last</i>)		NA Di	sabled	18 Mother's Nar	ne (First Middle	Maiden Surname)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	James Floyd					Moore	wason carrame,	
Z	shoul nd Me mark	ဍ	19a. Informant's Name/Relationship	ype. Print)	19b. Mailir	g Address (Street	-		er, City or Town, State	Zin Code)
	nd 2 stifth author 27 is		Barbara Mallory		1.	Pennsy			Balto,	MD 212511C
ē,	s 1 al		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location - City	or Town, State
Baltimore,	Page lent o nt: if ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		King Me		!	1 2007	_Randalls	where MD
alti	mit. partm sorta / inju		21. Signature of Funeral Service Licen			. Name and Addre	A 1000	March :		
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*	黄		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CH	F					Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):	- 20	0 .			- PS.
-	Examiner		Sequentially list conditions,	b		ertery	dieas	۷		7-1
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587		dic		.d						
×	death certificate at the death certificate at the death of the death o	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	of pregnancy				23d. Date of d	Inlivon
.O. Box	death atter	iciai	in the past 12 months?	1□Live birth 2 4□Pregnant at t]Ectopic pregnancy] Other <i>(sp</i> ec <i>ify)</i>	у		Month	Day Year
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Records, P.	Attending Physician: The law requires that the death certificate react. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
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Vital	nysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea			
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Division or	ding Ph		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day		Wor		28d. Describe I	now injury occurred	
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\leq	or At after d Direct in by	Certification:	4 Homicide determined	building, etc.	ry - At home, farm, stre . <i>(Specify)</i>	eet, ractory, office		28f. Location (S City or Tox	Street and Number or i vn, State)	Rural Route Number,
_	G □ □ □		29a. Certifier 1 Certifying Phy	vsician: To the best of	f my knowledge death	occurred at the tir	me date and place	and due to the	cause(s) and manner	as stated
	24 h	Medical	(Check only 2 Medical Examone)	iner: On the basis of and manner stat	examination and/or in	estigation, in my o	ppinion, death occu	rred at the time,	date and place, and d	ue to the cause(s)
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	Cove	- M	29c. License	e number		29d. Date signed (Mo.	nth, Day, Year)
	1		De lu	o gen	Albular	e D.	36942		April 9.	2007
	5	-	30. Name and address of person who o	ompleted cause of de	ath (Item 23a) (Type,	Print)		, .	VI /	
			B. TURAKHIA		09, Fred	with R	a. C9+	end in th	29d. Date signed (Mo. Apr 1 9, (, W) 2.	1228
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Year **Physician** MUTHONI 9:10 MAR 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL SALTI HORE MEMORIAL Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country) KEN VA 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months 1□M 2KF Days 9-29-8849 Vrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any inJury or other traumatic event, the Medical Examiner must be notified at 1XYes 2 No Director 10e. Street and Number Og. Citizen of What Country? Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 H If Yes, Give Year or Dates: 1 Never Married 2 Married 2 8 No Baltimore, Maryland 21215-0036 1 ☐ Yes 225No <u>ک</u> BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL-HARBURG CTR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Žip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State 20a Method of Disposition 1 Bulial 2 □ Cremation 3 □ Removal from State FAMILY CEMETERY.D 4 Donation 5 Dother (Specify) 21. Signature of Funeral Seprice Licenses 22. Name and Address of a cility 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm diate Cause (Final risk ase or condition sulting in death) **Physician** breast 4neurs meterstectic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a noneequence of): Examiner burial-transi l pue certificate be exec Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy jo Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9☐Unknown 9 Hunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division or Vital 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. Hospital or Attendi 24 hours after death. Funeral Director: 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATZ438946 MD 9, ZOO7

Registrar

DHMH 17 Rev 1/2001

State

30. Name an Address of person who completed cause of death (Item 23a) (Type, Print)

telaine

APR 1 2 2007

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bruce Lowell Mik		1- For State	tate of Ma	ryland /		artment rtificate			d Men	tal Hy	_	Reg. No.	201	7	11639	
Physicia	ın/	1. Decedent's Name (First, Middle,Last)									2. Date of Death				Time of Death	
Medical Exami	ner	Bruce Lowell M									April 5, 2				2045 hrs	
		4a. Facility Name (if not institution 9244 Three Oaks Dri		nd number)				4b. City, Town, or Location of Death Silver Spring					County of E			
Funeral		Social Security Number	6. Sex	7. Age	e (In vrs. la	ast birthday		Inder 1 Yea	<u> </u>	er 24Hrs.	8. Date of I				ace (State or	
Director		274-22-4162	1 X M 2		76	,	_	nths Day			1	7/193	F	oreian	y) Ohio	
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v any		10a. State 10b. County			10c. City,	Town or Lo	ocation								d. Inside City Limits	
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rdeath with the Maryland or items 23a or 28a-f show must be notified at once.		9244 Three Oaks		a Decedent	20901 Ever in U.S. 13. Was Decedent of Hispanic Origin? (S					ain2 / Sa	ocify Voe or		ted S		Indian, Black,	
eath w	uneral	1 Never Married 2 N	larried Arm	ned Forces?	No No	.5. 15.	If Yes, sp	ecify Cuba	n, Mexican	, Puerto I	Rican, etc.)	10-	White, e		IIIQIaII, DIACK,	
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ours a atura xamir	g b	15. Decedent's Education (Spe	ecify only highes	st grade com	pleted)	16a. Dece			ation (Give			16b. Ki	nd of Busin	ess/Indu	stry	
6 n 72 h an "n ical E	jet	Elementary/Secondary (0-12)	Colle	ege (1-4 or 5	i+)				5. DO 1401	use real	eu)		1	0	•	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Completed	17. Father's Name (First, Middle	Lost\	5+		Cons	ultar	1 t	18 Mother	's Name	(Eirst Middle			ig Se	ervices	
115- e filed al Hyg	BeC	Elbert Lowell A		L							ne (First, Middle, Maiden Surname lizabeth Overho			•		
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If iten 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		19a, Informant's Name/Relation	ship (Type, Prin	t)		19b. Ma	iling Addr	ess (Stre		-	ural Route N				Code)	
MD d 2 sho lth and n 27 is numati		Lisa Bond / Ste	epdaught	ter	1 -			e Anne Ct., Mo			•					
re, s l and f Heal If iten		20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Remo	oval from Sta		Place of Dis	sposition (i or other pla	Name of ce ace)	emetery,	Apr	il 10,	20c. Lo	ocation - Ci	ty or Tow	vn, State	
Baltimore, permit. Pages I ar Department of Hee Important: If iter		4 Donation 5 Other S					2			07	Fre	Frederick, Maryla				
Salt ermit. eparti mport		21. Signature Funeral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot										Cody	P.A.			
		9501 Catoctin Mtn. Hwy. Frederick, MD 23a. Part Fine the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									MD	21/01 approximate Interval				
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Box e death c the atten ed for us	· 📆	1 Yes 2 No 9 Ur	Juneary	Pregnant at Unknown	unie or de	5	Other (Specify)								
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	-	27. Manner of Death 28a. Date of Injury 28b. Time of Death 1 Natural 5 Paging FOUND: FOUND: FOUND:										28d. Describe how injury occurred Subject shot self				
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To To	Me	29b. Signature and title of certif		29c. License number					29d. Date signed (Mo				Day, Year)			
highi, no								O.C.M.E.				April 6, 2007				
1541		30. Name and address of person						-10:	MD 044	204		•				
1		•	ant Medical			Penn S	treet, B	aitimore	, IVID 212	201						
Si Regis	tate trar	31. Date filed (Month, Day, Year	1	32 Registra	ir's Signat	ure A	salls	9								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State	of Maryl		epartmei C <i>ertifica</i>				lental H	/giene Reg. No	office areas affi	17	1 9	c i. n
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	Physicia /Medic			у	Month April					Day Year 5, 2007 8:37pm M			M Th				
	Examin	1000	4a. Facility Name (/	If not institution	, give street and no	umber)		4b. City	, Town, o	r Location	of Death			c. County of I	Death	-	
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	Funeral		5. Social Security N		6. Sex 1 ☐ M 2 🗶 F		yrs. last birth	Months		Hours		8. Date of B (Month, L			Country)	_
	Director		128-14- Usual Residence of			8	9					March	8, 13	918	Net	Jer	sey
	yland now at		10a. State	10b. County		10c	. City, Town	or Location			•				10d.	Inside Cit	100
	e Mar ta-f sl	cto	Maryland Montgomery				Bethesda						1 ☐ Ye				
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	Director	10e. Street and Nu	mber			10f. Zip Code						10g. C	Citizen of What Country?			
	ath w s 23a rust l	ra		ulevar	ver in U.S. 13. Was Decedent of Hispanic Origin? (S					ooifu Voe or N	lo.	Unite					
	item:	Funeral	11. Marital Status 1 ☐ Never Marr	ried 2 Marr	Armed F	orces?	III 0.5.	If Yes, sp	ecify Cub	an, Mexic	an, Puerto	Rican, etc.)	10-		White, etc		
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215	within 7 ene. than "r he Med	Completed	Elementary/Seco			(1-4or 5+)		life. DO NOT	use retire	d)	JO. 07 11 077	9					
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and	ould be fi Mental H larked otl	Be	17. Father's Name				. 1 1			TO. WOO	Her 5 Halli			,			
Maryland	s 1 and 2 should be filed within 72 ho Heath and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical.	ပ	19a. Informant's N		rold P. M	lacaona		Mailing Addres	ss (Street	and Num	ber or Rui			White or Town, Sta		ode)	
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ē,	s 1 and 2 f Health item 27 i		20a. Method of Dis	position		20	0b. Place of	Disposition (Na	ame of	1		Date		Location - Cit			20014
E OE	Page lent o nt: If			☐ Cremation 5 ☐ Other (S	3 □Removal fror pecify)	n State		ulpepe	r	V	12 *	ril 2007	C	u1pepe	r. V	irgin	ıia
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Fureral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey F Bethesda-Chevy Chase, Inc. 7557 Wisc									Fune	ral I	Home/			
Δ	e a E e e	0.0		len !) Sepher	A MOC	0335	Bethes	sda.	Mary	land	20814-	3501	O) MIS			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											e ween Death			
	Physician		Immediate Cause (Final disease or condition												Joan		
-	/Medical Examiner		resulting in death)	1		o (or as a cor							Dis	sease			
		<u>_</u>	Sequentially list co	onditions,	b. Pneu	monia o (or as a co	a With Pleural Effusion consequence of):								1		
	uted Insit	Ë	if any, leading to in cause. Enter Und Cause (Disease of	erlying r injury	6			Diseas	20								
(7)	be executed sician and burial-transit	Exa	that initiated event resulting in death)	Last		o (or as a co			30								
2/5	cate be executed bhysician and the burial-transit	dical Examiner			d. Pulm	onary	Embo1	ism									
္ ဖ	certifica nding ph use as th		IF FEMALE:														
30×	leath certific attending p I for use as	Completed by Physician/Me	23b. Was deceder			birth 2 🗌	Fetal death	3 □Ectopic		у				23d. Date of Month			Year
0.0	The law requires that the death te has been signed by the atter age 2 should be detached for u	/sici	1 ☐ Yes 2	X No	4∐Pre 9⊟Unk	gnant at time (nown	of death	5 🗌 Other (specify) _							_	
N.	w requires that the d been signed by the should be detached	Ph			ons contributing to	death but no	t resulting in	the underlying	cause giv	ven in Par	t 1.	23e. Die	d tobacco	use contribu	ute to the	cause of d	death?
ds,	signe d be	d by			nic Obst							1[Yes	2 No 3	☐ Probab	oly 4 🕱	Unknown
- Jo	w req been shoul	ete			Atrial							24a. Wa	as an	24b. We	re autops	y findings	available
- a	sician: The law certificate has b irector, page 2 s	텵										au pe 1∐ Yes	topsy rformed? 2 X N	l pric	or to comp ath?	oletion of c □ No	ause of
I I	an:] tifical tor, p	Be Co	25. Was case refe	erred to medica		ertens:	TOII	-		26. Pla	ice of Dea	th (Check onl		10 1	1163 2		
7 >	nysician: nis certific director,	To B	examiner? 1 ☐ Yes 2 ∑	No	Hospital:	Inpatient	2 ☐ ER/Out	patient 3□ I	DOA Oti	her: 4 🗆	Nursing H	ome 5 Re	sidence	6 □Other	(Specify)		
(OX+)	Attending Physician: r death. ector: After this certific: by the funeral director, I		27. Manner of Dea	ath 5 □ Pendir	/0.4	te of Injury onth, Day Ye	28b. T ar) Ir	ijury	28c. Inju Wo			28d. Describ	e how inj	jury occurred			
Sio	tendil eath. tor: A the fu	catic	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	gation		A11 6	M	l	Yes 2	□No	001.1	(0)	(4)		7 / 1/	.1
NCCAX+MY 4	l or Attend after death. Director: J	Certification:	4 ☐ Hornicide		ningd 200. Fld	ce of injury - Iding, etc. (S		m, street, fact	огу, опісе				own, Sta	and Number ate)	or Hurai i	Houte Ivum	iber,
E	Hospital 24 hours a Funeral I tely filled	ပ္မ	29a. Certifier	1 ertifyii	ng Physician: To t	he best of m	v knowledge	death occurre	ed at the t	ime, date	and place	and due to t	ne cause	(s) and mann	er as stat	ted.	
EHNE MC	To the Hospital or Attendla within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one)		Examiner: On the												3)
LL	To the within 2 To the comple	Me	29b. Signature (n	d title of certifie	N	,	_	2	9c. Licen	se numbe	r O			Date signed (ay, Year)	
	9		1/19	wan,	Low	t,	Si mo	1	000	651	182	-	4	1610	+		
	270		30. Name and add	dress of person	who completed ca												
_				lourani-				d Georg	getow	n Ro	ad Be	thesda	, Ma	ryland	208	14	
	Sta Regist	ate	31. Date filed (Mo			. Ragistrar's	oignature	boort									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 200<u>7</u> Month 10:05 a_M **Physician** April 8, Rose Marie Niven /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Villa Nursing Home Baltimore Catonsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 9, 1927 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Maryland 1 □ M 2 🔽 F 79 Yrs. 216-20-4235 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjuy or other traumatic event, the Medical Event. 10d, Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 21228 United States 711 Academy Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No White ģ 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Filing Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Hyland Ethel Madkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rose Armentrout - Daughter 5941 Cecil Avenue, Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4-11-2007 Brooklyn, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature L Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 omplications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part1 Enter the disease, or of shock, or heart failure. List Immediate Cause (Final MYCEARDIA disease or condition resulting in death) 13.10 Due to (or as a consequence of): Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ATHEROSE CEROTT Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) □Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death

law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760 attending physician à this I or Attending Patter death.

Physician

/Medical

Examiner

Funeral

Director

Certification: To

5 ☐ Pending investigation 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

29a. Certifier

6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

1 □ Yes 2 □ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D0025844

29d. Date signed (Month, Day, Year) 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54/1 OCD FREDERICK RD COMMERFORD, MO

Registrar

filled in by

completely

7

within 24 hours a To the Funeral L

31. Date filed (Month, Day, Year)

APR 1 2 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First Middle, Last) Veat **Physician** 04 0.5 2007 /Medical Town. or Location of Death 4c. County of Death la. Facility Name (If not institution, give street Examiner MOI Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Months Hours 1**№**M 2□ F Director 233-60-3279 68 West Virginia 1/19/39 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 USA death v Funeral 501 S. Fulton Ave 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine and. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify Specify þ 3 ₩Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Station 0 Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Elizabeth Costello James William Painter, Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 519 S. Nancy Wills Fulton Ave, Baltimore, Maryland 21223 20b. Place of Disposition (Name 20c. Location - City or Town, State 20a. Method of Disposition Baltinore Crematery 1 ☐ Burial 2 StCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) @ Loudon Park 4/7/07 Baltimore, Marvland 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hour /Medical consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner to (or as a consequence of To the Hospital or Attending Physiclan: The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ № 6 24a. Was an page 2 s autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 40 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending Injury 1 Natural ours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification **8001** 32. Registrar's Sign 31. Date filed (Month, Day, Year) State

Registrar

			For State	State	of Maryland	•	rtment of H			giene Reg. No.	0007	1161.3		
		Registrar 1. Decedent's Name (First, Middle, Last)							2. Date of De	ath	<u> </u>	3. Time of Death		
В	Physici		VALENTIN		RICHAG	Month APRIL	Day	2007	2:15PM					
	/Medic		4a. Facility Name (If not institution		ENTER		Location of Death			County of Death				
	CXAIIIII	e.	JOHNS HOPKINS	BAYVIEL			BALTI		B	ALTIMO!	LE LITY			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th v Year)	9. Birthp	lace (State or Foreign		
	Director		580-06-5468	1□M 21 XF	68	Yrs.	World Days	Tiours With,	Jan 15	, 19:	39 Saint	Martin, VI		
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation				T ₁	0d. Inside City Limits		
	aryla shov	7										X Yes 2 No		
	he M 28a-f otifie	Director	MD Balti	more	ват	timore	10f. Zip Code			10a Citiza	en of What Cour	ntry?		
	a or	ä	8645 Heatherm	ille Road			2123	6			SA	,.		
	eath	era	11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13. 1	Was Decedent of H	ispanic Origin? (S	pecify Yes or No		4. Race - Americ			
(0	r iter	Funeral	1 ☐ Never Married 2 ☐ Mar	ried Armed F	2 No	-	f Yes, specify Cuba		o Rican, etc.)		Black, White,	etc.		
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7	lled w Hygie ther to nt, th		17. Father's Name (First, Middle,	l ast)		Hous	sekeeper	18. Mother's Nan	ne (First, Middle,			LIIas		
and	d be f	Be c	Jean Chittick					Lyvia	, ,		•,			
<u></u>	should mark matil	은	19a. Informant's Name/Relations	19b. Mailir	ng Address (Street			er, City or	Town, State, Zip	Code)				
2	₽ £ C ₽		Martine Ticha	rdson (Da	aughter)	864	45 Heathe	rmill Rd	. Baltin	nore,	MD 2123	36		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other place	ce)	Date	20c. Loc	ation - City or To	own, State		
E	Page nent c int: If		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (1 State		emetery N	! ,	. 07		Thomas,			
alti	mit. partm porta y Inju		21. Signature Funeral Service	Lisensee		22	2. Name and Addre	ss of Facility			,			
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	/Medical Examiner		resulting in death)	Due to	o (or as a consequ	uence of):								
В	LAdiminer	<u></u>	Sequentially list conditions, Due to (or as a consequence of):											
Ţ	ted 1sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	d Due to	(or as a consequ	derice oi).								
	The law requires that the death certificate be executed ate has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	xar	that initiated events resulting in death) Last	c	o (or as a consequ	uence of):								
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.89	ificate g phy as the	edic	157 (2)	-0.				200						
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B.	deatle atte	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No		birth 2 ☐ Feta gnant at time of d		Other (specify)	<i>'</i>			Month	Day Year		
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ec	has by ge 2 sh	Completed by							24a. Was	psy	prior to co	opsy findings available impletion of cause of		
Division or Vital Records,									1□ Yes	2 No	death? 1 ☐ Yes	2 No		
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or	Physiclan: this certific ral director,	2	1 Yes 2 Ho	1 1	npatient 2 e of Injury	28b. Time of	" 0 DOX	4 🗆 Nursing r	fome 5 ☐ Resi 28d. Describe			(y)		
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isi	Attending r death. ector: After by the fune	lical	3 Suicide 6 □ Could	not be 28e. Plac	e of injury - At ho	me, farm, st	reet, factory, office					al Route Number,		
Ö	all or A	Certification:	4 ☐ Homicide determ	buil buil			City or 10	r Town, State)						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,			ing Physician: To the										
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DOO631								29d. Date sign			Day, Year)			
							Do	06316-	16 2007					
•	$\langle \chi \rangle$		30. Name and address of person					ANIRUDH SRIDHARAN						
			31. Date filed (Month, Day, Year	TERN	Registrar's Signa	LALT ature	IMORE	> M >				<u>.</u>		
	St Regist	ate rar	APRI2	2007	er di	Los	AS .							
	MH 17 Rev 1/9					3								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 12:05PM a laru 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randall st thive 5 OWN imore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 12/17/20^{ar)} Hours Months 1□M 2 F 86 051-16-9943 Yrs. Director New York Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County ul Hygiene. other than "natural", or items 23a or 28a-f show vent. the Medical Examiner must be notified at Baltimore Baltimore MD. 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 2118 Northland Road 21207 Funeral 12. Was Decedent Ever in U.S. Armed Forces %, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Be Completed by 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any hijury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Granahan Sarah Murray Anthony ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2400 Birch Drive, Baltimore, Md. 21207 Nancy J. K. O'Neill, executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 4/13/07 Owings Mills, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loring Byers Funeral Directors Inc 8728 Liberty Rd., Randallstown, Md. 21133 Hancka remmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years oronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Completed by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🗖 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? res 2/2 No certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 🗹 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA neral Director; After this filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Randal 540101 NbI a Cour hristine a 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ames Eari Rodi		State of maryland 1 = 5 pm.	tment of Health and Mental I ficate of Death		a. No. 200	7 1164
Physicia	ın/	1. Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death
ledical Exami	ner	JAMES EARL RODRIGUEZ 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	April 8, 200	4c. County of Death	1027 hrs
		4403 Flintville Road	Darlington	201	Harford	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last				hplace (State or
Director		073-62-6402 1XM 2F 28		o7/03/	1978	n NEW YORK
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location			10d. Inside City Limits
*			ABERDEEN			1 Yes 2 X No
Maryland 28a-f show d at once	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	itry?
th the Maryland 23a or 28a-f sho notified at once	Q re	741 CUSTIS ST.	21001		U.S.A.	
MD 21215-0036 42 should be filed within 72 hours after death with the Maryland Ith and Mental Hygiene. 11 77 is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer		14. Race - Ameri White, etc.	can Indian, Black,
er deat	핇	1 Yes 2 X No	1 X Yes 2 No specify: Pu			SPANIC
ırs afte	d by	or Dates:	16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business/I	
72 hor	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use r	etired)		
5-0036 led within 7 Hygiene. I other than the Medica	Compl	12th grade	N/A		N/A	
15-C	ပိ	17. Father's Name (First, Middle, Last)		me (First, Middle, M	laiden Surname)	
2121 Ould be fi Mental marked ic event,	o B	ADAM RODRIGUEZ 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of	STEVENS or Rural Route Num	per, City or Town, State	, Zip Code)
MD od 2 sho lith and m 27 is sumati	-	Aida Rodriguez/Wife	4403 Flintville Rd.	, Whitefo	rd, Md., 2	1160
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' or other traumatic event, the Medical		20a. Method of Disposition 20b. Pla	ace of Disposition (Name of cemetery, ematory or other place)	Date	20c. Location - City or	Town, State
Page ment o		4 Ponation 5 Other Specify: HAF		4-13-07	ABERDEEN,	
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is minjury or other traumatic.		21. Synature of Juneral Service Licensee	22. Name and Address of Facility WM C BROWN COMMUN			
Physician	4	23a. Part I. Enter the disease, or complications that caused the death. D	321 S PHILADELPH Do not enter the mode of dying, such as cardial			Approximate Interval
/Medical	1	failure. List only one ause on each line. Immediate Cause (Final disease a. Seizure disorder				Between Onset and Death
∽ Examiner		or condition resulting in death) Due to (or as a consequence of):				
	٦	Sequentially list conditions, if any, leading to immediate b. Malformation, left Due to (or as a consequence of):				
	mine	cause. Enter Underlying Cause (Disease or injury that initiated				
lusit led	Exa	events resulting in death) Last Due to (or as a consequence of):				
lox 68760, eath certificate be executed a attending physician and for use as the burial - transit	Medical	d. UNPENDED AMENDED 27 PORT	E, g867, 5/2/07 TT			
'60, ate be	Med	IF FEMALE: 23c. If yes, outcome of pregna	IC, 8007, 3/2/07 11		23d. Date of delivery	,
687 certific	sician/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pres	nancy	Month [Day Year
Box e death the atter	ysic	1 Yes 2 No 9 Unknown g Unknown	5 Other (Specify)			
	y Phy	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	, many	pacco use contribute to	
rds, P.O. requires that the been signed by hould be detach	ed by			1 Yes		pably 4 V Unknown
cords law requi has been 2 should	plet			24a. Was a autops	sy prior to o	topsy findings available completion of cause of
Rec The la	Completed			1 ✔ Yes 2		es 2 No
Vital Rechysician: The this certificate	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 E	26.Place of Death (Cher ER/Outpatient 3 DOA Other Nur		Residence 6 🗸 Other	u Saana
n of V ing Phys After this	P	1 Yes 2 No	28b. Time of Injury 28c. Injury at Work?		ow injury occurred	. Scerie
OD Conding ath.	tion	Natural 5 Pending	1 Yes 2 No			
ViSi or Att fter de Directe	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hon	ne, farm, street, factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Ru	ral Route Number, City
Spital sours a neral 1	Certification:	4 Homicide determined (Specify)		0. 10,111, 0.		
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge (need) Medical Examiner: On the basis of examination and				
To t To t	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo.	
		Quet	O.C.M.E.		April 9, 2007	
	}	30. Name and address of person who completed cause of death (Item 2	(3a)			
X)			11 Penn Street, Baltimore, MD 212	201		
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regulary's Signature APR 1, 2, 2007	H back			
DHMH 17 Rev 1/2	_	TO COUL MEDICAL DE	ORIGINAL			

			For State Registrar	tate of Maryland / [Department of F Certificate of		lental Hygie	2001	11646	
	Physicia		1. Decedent's Name (First, Middle, Last) Elizabeth	Ruley			2. Date of Death Month April 7,	Day Year 2007	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give stree St. Catherine's Nur: 5. Social Security Number 6. Sex	at and number)	Emmi	tsburg	8. Date of Birth		erick	
	Funeral Director		220-18-9973 Usual Residence of Decedent	avv.	Yrs. Months Days	Hours Min.	NOV. 7,	1921 Mary	place (State or Foreign Party) and	
0	f ehow	or	10a. State 10b. County Md. Frede	10c. City, Town		nmitsburg			10d. Inside City Limits 1 ☐ Yes 2XXNo	
4	a or 28a- the notif	Director	10e. Street and Number 331 South Seton A		10f. Zip Code	21727	10g	Citizen of What Cou	intry?	
d 21215-0036	perfilt. Tages I and a Should be light with 12 hours and beautiful or may not perfilt. If then 27 is may have been many and perfect them 27 is marked other than "natural", or lieme 23a or 28a-1 ehow eny injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral	11. Marital Status 12. 1	Was Decedent Ever in U.S. Armed Forces? 1 _Yes _2 _No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
21215-0036	ne. han "natural e Medical E	Completed t	15. Decedent's Education (Specify only highest grade co	on 16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work d)		b. Kind of Business/li Own Ho	ndustry	
and 21	ntal Hygier ed other the	Be	12 17. Father's Name (First, Middle, Last) William S	porrer	Homema	18. Mother's Nam	e (First, Middle, Ma ora Lint		me	
Maryland	h and Me	ဥ	19a. Informant's Name/Relationship (<i>Type</i> , Elizabeth P. Sixt/Da	Print) 19b	Mailing Address (Street	and Number or Rur	al Route Number, C	City or Town, State, Zi		
Baltimore, I	ient of Healt nt: If Item 27 ry or other 1	***************************************	20a. Method of Disposition 1 Burial 2 XCremation 3 Rem 4 Donation 5 Other (Specify)	20b. Place or cemeter	f Disposition (Name of ry, crematory or other pla	сө)	Date 20	c. Location - City or T DWSON, Mar	Town, State	
Balti	Departm Imports eny inju		21. Signature of Funeral Service Licensee	Russ	22. Name and Addre			Funeral H ryland 212		
F	hysician and business and busin	dical Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence	of): SoupT of):) O	or respiratory arrest		Approximate Interval Between Onset and Death Conset and Death Conset and Death	
	ine taw requires ther the beath berinical title has been signed by the attending phoage 2 should be detached for use as the	Physiclan/Med	in the past 12 months?	If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	n 3 ⊟Ectopic pregnanc 5 ⊟ Other (specify) _	у		23d. Date of delin	very Day Year	
ds, P.	n signed by	ρ	Part II. Other significant conditions contrib	uting to death but not resulting i	in the underlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to		
	certificete has been si rector, page 2 should I	Completed						prior to c	topsy findings available completion of cause of	
ō	ang rays n. After this funeral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes No	28a. Date of Injury 28b.	Time of 28c. Injury Wo	her: Nursing H	th (Check only one) ome 5 Residence 28d. Describe how	ce 6 Other (Special injury occurred	cify)	
á	tal or Attent is after deatl al Director: ed in by the	Certification:	a Could not be	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	lo the Hospital within 24 hours a To the Funeral completely filled	edical	(Check only 2 Medical Examiner one)	an: To the best of my knowledg : On the basis of examination ar and manner stated.	nd/or investigation, in my	opinion, death occur	rred at the time, date	e and place, and due	to the cause(s)	
D	within To the comple	Σ	29b. Signature and title of certifier South Country Description Des	unpel-fe	MEDIDE	se number Hooyy	957	1. Date signed (Month	, Day, rear)	
_	M		Name and address of person who comp	Eufel-fe	(Typle, Print) PRTIER	DOEL	-1230	Jue la	1) 2/12	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 2 2007	32. degistrar's Signature	hoods .	•	Ţ	<u> </u>		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Amend #10e Per FH G866 4/12/07 III of Death 64 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edward B. Savage 4:35pm April 7, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Securify Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2□ F 244.07.1857 aL NO Director 10/12/1912 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Bautimone MD 1 DXYes 2 □ No **Funeral Directo** 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21239 1325 Winston Avenue or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Sayage, Edward Baltimore, Maryland 21215-0036 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced "natural" Completed if Item 27 is marked other than "natu or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Buşiness/Industry (Give kind of work done during most of working life. DO NOT use retired) Navy Air Elementary/Secondary (0-12) College (1-4or 5+) Airolane Mechanic 2nd grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ewis Savage ourane 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1325 Winston Avenue Baltimone MD 21239 permit. Pages 1 and 2 Department of Health a Important; if Item 27 is any injury or other trai once. Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □Removal from State Windsor Mill, MD 14/07 King Memoral Park 4 Donation 5 ☐ Other (Specify) Vaughn C. Greene Funoral Services 22. Name and Address of Facility 21. Signature of Funeral Service Licensee mo1363 4905 York Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ung Lancev 2 months **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed? 2 1 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29h. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 00056156 / Jum m. C 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Suzanne Caccamese

31. Date filed (Month, Day,

32. Registrar's Signature

6565 North Charles Street Baltimore, Maryland

			1 - State Registrar	Certificate of Death Reg. No. 7 1 1 5 4 5
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Amonth Day Year 11:480m
	/Medic		Morgan	Jat Chell April 9 2007 11; 48 pm 4b. City, Town, or Location of Death 4c. County of Death
3	Examin	er	4a. Facility Name (If not institution, give street and number)	SPITAL BALTIMORE NIA
	Funeral	0		(In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		220-80-6000 12M 20F	46 Yrs. Months Days Hours Min. (Month, Day, Year) Country) NOV. 12,1960 MARVLAND
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location 10d. Inside City Limits
	shov shov	o.	1.1	0 1 Noves 2 I No
	the N 28a-f	ect	MARYLAND N/A 10e. Styleet and Number	10f. Zip Code / 10g. Citizen of What Country?
	death with the Maryland rns 23a or 28a-f show r must be notified at	Funeral Directo	100011	AVENUE 21205 USA.
	death ms 2	nera	11. Marital Status 12. Was Decedent E Armed Forces?	
٥	within 72 hours after ene. than "natural", or Ite he Mrdical Examine		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N	1 ☐ Yes 2 No Specify: Specify: Specify: 1 ↑ ↑ ↑
0030 0030	ural";	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
μ	in 72 r "nat redica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind of work done during most of working
7	y with giene. r thar the N	mo	Elementary/Secondary (0-12) College (1-4or 5	TRUCK DRIVER TRUCKING COMPAN
D	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
yiai	Menta	To E	JOHN JULIUS S	ATCHELL BARBARA ADELAIDE WASHINGTON
Mar	2 sho		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e) O	iges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyglene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	(20a, Method of Disposition	20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
	ages nt of l		1. Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crematory or other place)
Saltill	permit. Pag Department Important: I any Injury o		4 □ ponation 5 □ Other (Specify) 21. Signature of Funeral Service License	GARRISON FOREST: 04-13-07 OWINGS MILLS, MD
n	permit. Departn Importa any Inju		Jacquelia & Ko	22. Name and Address of Facility BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIHORE, MD. 2/2/1
t	46		23a Part1. Enter the disease, or complications that caused	the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
	Physician		Imprediate Cause (Final	Cerebra Hermition 2 days
1	/Medical		disease or condition resulting in death) Due to (or as	a consequence of):
	Examiner	4	Sequentially list conditions, if any, leading to immediate b Due to (or as	Intracranial Hemorrhage 3 days
W	ted nsit	nine	Cause (Disease or injury	a consequence or.
7	execun n and ial-tra	Examiner	that initiated events c	a consequence of):
2	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit			
9	certificate be ding physicia se as the bur	Medical	IF FEMALE:	
gox	ath ce ttendi or use		23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year
5	the at	Physician	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5 Other (specify)
7	law requires that the death, as been signed by the atten 2 should be detached for u		Part II. Other significant conditions contributing to death be	at not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ecords,	uires signa Id be	d by	Hyperter	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ❷Unknown
000	w red	lete	1.01	24a. Was an 24b. Were autopsy findings available
r	The la	Completed		autopsy prior to completion of cause of performed? death? 1 □ Yes 2 ☑ No 1 □ Yes 2 □ No
VITall	sician: The law certificate has b irector, page 2 s	Be C	25. Was case referred to medical	26. Place of Death (Check only one)
O _ O	Physician: r this certifica ral director, I	70 1	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1,⊠ Inpatie	
	ing P	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Inju (Month, Da)	Year) Injury Work?
SIO	Attending it death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be 289 Place of init	M 1 ☐ Yes 2 ☐ No Iry - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
UNISION	lor A after of Direction by	Certification:	4 Homicide determined building, etc	City or Town, State)
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.			of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	he Ho in 24 he Fu pletel	Medical	one) and manner sta	
	with To t	Σ	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
i	150		James Hodelnak	MU RES-000 April 9 2007
	241		30. Name and address of person who completed cause of d	600 N. Wolfe Street, Bultimore, MD 21287
	Sta	ite		ar's Signature
	Registi		APR 1 2 2007	with franks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Harry B. Sadler /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner oser TIV If Under 1 Year | If Under 24 Hrs. 6 Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 □MM 2 □ F MD Director 212-12-2805 84 8-29-1922 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🏖 ☐ No MD Harford Abingdon Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 3704 Sewell Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW I I filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3 HWidowed 4 ☐ Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Laboratory Technician Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Unknown Norfolk Blanchard Sadler ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Pages 1 and z surment of Health ar ortant; if Item 27 is R. Russell Sadler-Brother 3919 College Ave., Ellicott City, MD 21043 of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important; If any injury or Bayview Crematory 4-7-07 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral Service Licensee 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conse un nce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9∐Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hronic 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 ☐ Homicide filled in Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) refcal wacuine 0063176 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. gistrar's Signature 31. Date filed (Month, Day, Year State

DHMH 17 Rev 1/2001

Registrar

APR 1

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07-02657 Mary J. Santucci Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ April 7, 2007 1735 hrs Medical Examiner Marv J. Santucci 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2 McArthur Ct. #C Cockevsville **Baltimore County** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Country) IOWa Months Days Hours Min. Director Oct. 22, 1941 65 479-46-6208 1 M 2 XF Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 1 Yes 2 X No 28a-f show Baltimore Cockeysville Md. Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
anti: If Item 77 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 McArthur Ct. #C 21030 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. Never Married 2 Married 2 X No Yes 4 Divorced White If Yes. Give Yea Yes 2 X No specify: Specify Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 2 Executive Assistant Insurance 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Robinson Margaret Kurtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14217 Quale Creek Way #101 Sparks, Maryland 21152 Mr. James Santucci/Son 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition portant: If it crematory or other place) 1 Burial 2 X Cremation 4/11/07 Towson, Maryland Hilltop Service Corp. Donation 5 Other Specify 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road Towson, Maryland 21204 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical Death a. Cirrhosis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown g Unknown ned by the a detached fo o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown σ. Chronic Obstructive Pulmonary Disease The law requires Completed Records, 24a. Was an 24b. Were autopsy findings available CARDITYASKULAR DISCASE autopsy prior to completion of cause of has performed? death? page 2 1 🗸 Yes ✓ Yes 2 certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Other₄ Hospital: DOA Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 ဥ 1 V Yes 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: ✓ Natural Pending Yes 2 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 8, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 **Deputy Chief Medical Examiner** 31. Date filed (Month Day Year) gistrar's Signatu State 2007 Registrar

			For State Registrar	State of	Marylar		artmen rtificat			and M	ental Hy	1	007	116	51
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	Funeral			Sex 1 M 2 ☐ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day May 1,	Year)	9. Birth Coi	place (State	or Foreign
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	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside C	ity Limits
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215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show thrt, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							31000000	hite	
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Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [☐Removal from State	20b. F	Place of E cemetery,	Disposition (Name of crematory or other	olace)	April 14,		c. Location - City o		
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	Hospi 4 houn Funer ety fill		(Check only 2 Medical Exa	Physician: To the best aminer: On the basis	of examina	owledge, ation and	death occurred at th Vor investigation, in I	e time, date a ny opinion, de	and place, and due t eath occurred at the	to the cau	se(s) and manner e and place, and d	as stated. ue to the cau	se(s)
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Medical	one) 29b. Signatura and title of certifier	and manner s	tated.		29c. Lic	ense number		29d	I. Date signed (Mo	nth, Day. Yes	1 <i>r</i>)
	F ≥ 5		Day De.	\sim			_	060	1 6		April 4		
	nU		30. Name and address of person who	o completed cause of	death (Iter	n 23a) (T		1000	100		whrit 4	, 2007	
	50		Asefa J. Mekonne					oad, S	uite 111,	Rocl	kville, M	faryla:	ad 20854

State

Registrar

Coarle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death April 2007 5:55 6, A M Donald Norman Schuck 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 2 □ F 60 432-84-6013 November 20, 1946 Arkansas Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 No 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Oak Knoll Terrace 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Corporate Construction Elementary/Secondary (0-12) College (1-4or 5+) Vice President Bonding 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zelma Fisackerly Jones

þ Completed Be ပ

traumatic event, the Medical

d 2 should be filed within the and Mental Hygiene.
7 is marked other than "

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

death

within 72 hours after

altimore, Maryland 21215-0036

Box 68760

P.0.

Division or Vital Records,

Director

Funeral

Physician /Medical Examiner

burial-transit attending physician the for use as the detached signed by t peen certificate has page 2 funeral director, After this

pe ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After tl filled in by within 24

Examine Physician/Medical ģ Be မ Certification: Medical

IF FEMALE 9 Unknown Completed 27. Manner of Death 1 X Natural 2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

Norman Joseph Schuck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Oak Knoll Terrace, Rockville, Maryland 20850 Vickie Lynn Schuck / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation April 14, 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Cremetorium, Inc. 2007 Bethesda , Maryland 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral-Service Licence Engeletta Payris M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, deart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2🗓 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 201) (Type, Print)

29c. License number

D26540

29d. Date signed (Month, Day, Year) April 6, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Approximate Interval Between Onset and Death

3 Years

Months

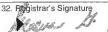
6

Day

16220 Frederick Road, #213, Gaithersburg, Maryland 20877 M.D. Schoenberger,

State Registrar

31. Date filed (Month, Day, Year) 2007



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April Day 2007 **Physician** Kenneth A. Souder 8, 5:40 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner National Lutheran Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) December 22, 1910 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 150-09-3439 96 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Interm 27 is marked other than "natural", or items 23a or 28e-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28e-f shov other traumatic event, the Madical Examiner must be multified at 1 X Yes 2 No Gaithersburg Maryland Montgomery Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number United States 20886 19133 Roman Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White þ 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Fire Captain 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert B. Souder Raechel Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steven Souder / Son 19133 Roman Way, Gaithersburg, Maryland 20886 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Absecon Methodist 20a. Method of Disposition April 16, permit. Pages of Popertment of Himportant: If ite any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Absecon, New Jersey 4 Donation 5 Other (Specify) Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Licenses Rockville, Inc., 300 West Montgomery Avenue M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers Dement month **Physician** 6 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as tha burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2. No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier maller MP DOU5061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel George Maller M.D. 9701 Veirs Drive, Rockville, Maryland 20850 Gode 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 0155 A M Swear engin Walter 4 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Coastal Haspice. 5. Social Security Number At The Lake Wicomico Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk 1 M 2 ☐ F Months 258-43-8567 35 Sept 15, 1971 Usual Residence of Decedent 10a. State unk 10c. City, Town or Location 10b. County 10d. Inside City Limits White Lake 1 ☐ Yes 2 No MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3300 Pontiac Road Lot 48386 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. unk 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deershead Hospital 351 Deershead Hospital Road Salisbury, MD 21802 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4□Donation 5♥Other (Specify) in state Signature of Euneral Truice Lensee Ronald Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) Metasketic Due to (or as a consequence of): Sequentially list conditions if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events He to for as a porsequence of resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical xaminer

Department of Important: If it any injury or conce.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. and the file may be anarked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be r.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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The law requires that the death certificate be executed sician and burial-tran as the been signe should be or Attending Physician:

P.O. Box 68760,

Division or Vital Records,

To the Hospital

Examiner Physician/Medical þ Be Completed certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Certification: To

				1 ☐ Yes 2	No 3 Probably 4 Unknown			
				24a. Was an autopsy performed? 1∐ Yes 2☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 27 No			
25. Was case referred to medical			26. Place of D	eath (Check only one)				
examiner?	Hospital: 1							
27. Manner o Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred			
3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		nome, farm, street, factorify)	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)			
29a, Certifier To Certifying P	hysícian: To the best of my kn	owledge, death occurre	ed at the time, date and pla	ce, and due to the cause(s)	and manner as stated			

29	a. Certifier
	(Check onl
	one)

31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier	111
(D)	UN.

2

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Coesto Jand

32. Registrar's Signature

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Physician THOMAS 943 PM March 2007 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A HOSPITAL THE JOHNS HOPKINS BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 213.36.7397 66 Yrs Director MD 29 1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or items 23a or 28e-f show rent, the Madical Examinar must be notified at MD N/A Baltimore 1 XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2127 Aiken Street 21218 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Black Specify: 3 ☐ Widowed 4 ☑ ivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Baltmone City 12th grade tyears 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ina Jigaells Gametta Brown ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gameta Matthews-Lincoln/Niece 2127 Aiken Street nt of Health a :: If Itam 27 is r or other tra Baltmore MD 21218
Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Baltimore MD Holly Hills 04106/07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaughen C. Greene Funeral STVCS 21. Signature of Funeral Service Licenses aughn Road Britimore MD 21212 York 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final disease or condition resulting in death) CANCER Physician BREAST UNCLEAR /Medical Due to (or as a consequence of): Examiner LUNG CANCER UNCLEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of). attending physician for use as the buria Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I been signed by the should be detached 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 1 Yes 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 ☐ Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After To the Hospital or Atterways within 24 hours after death.
To the Funeral Director: Aft 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Coufd not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 DICAY AKSOY MD APRIL 9, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE OLCAY AKSOY, MD THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET MARYLAND 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. 200 Year **Physician** Day GISELE MIREILLE THOMAS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 148-30-0950 86 May 5, 1920 France Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show be notified at Director 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Laurel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō **23**a 3565 Ft.Meade Road U.S.A. #412 20724 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status r than "natural", or iten the Medical Examiner Black, White, etc. 1 ☐ Yes 2**XXI**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2\(\frac{1}{2}\)No Specify. Specify: ģ White 3 Vidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 Year Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finand Mental H Francisque Perrin Leona Bridoux Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. William F. Thomas Viale Trento #88, Vicenza, Italy son 36100 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State West Arundel Crem. 4/12/2007 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland permit. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. \angle M00770 LI 313 Talbott Avenue Laurel, Maryland 20707 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, buly one cause on each line. 23a. Part1. Enter the disease, o shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Culsa Mute S quanticity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed hughra physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes No. Completed tensi av Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an cate has by page 2 s autopsy perform certificate 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29c. License number

i) #33 29b. Signature and title of ce 29d. Date signed (Mojnth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6201 GreenheltRd, Suit in-15 College PIC OKWARA hi 32. Registrar's Signature 31. Date filed (Month, Day, Year! Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

16b. Kind of Business/Industry Martin Marietta 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2548 Beckleysville Road Freeland, Maryland 21053 20c. Location - City or Town, State Catonsville, Maryland Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Approximate Interval Between Onset and Death tructive ful monary Dislase 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Tyes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) tx Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D28987 2007 30. Name and address of pers of o completed cause of death (Item 23a) (Type, Print) MD BALTO. LOCH RAVEN BLUD

Year

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Maryland

USA

white

900

31. Date filed (Month, Day, Year)

CARL SPERLING, M.D.

29b. Signature and title of certifier

32 Registrar's Signature

5601

um

DHMH 17 Rev 1/2001

Registrar

07-026	384	1		
C 4	_	~	 -1-1	

Edwin C. Truscla		Stat 1- For State Registrar	e of Maryland / Departm <i>Certific</i>	ent of Hea ate of Dea		/lental Hy	giene Reg.	No. 200	7 11659
Physicia	n/	Decedent's Name (First, Middle,L					Date of Death Month E	ay Year	3. Time of Death
Medical Examir	ier	4a. Facility Name (if not institution,	TRUSCLAIR give street and number)	4b. City	/, Town, or Loca	ation of Death	April 8, 2007	4c. County of Deatl	1550 hrs
		4341 Sheldon Avenue	,		timore				
Funeral Director		219-27-4746	Sex 7. Age (In yrs. last bin			Under 24Hrs. Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Bii Forei Co	
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town						10d. Inside City Limits
	ь	Md	Bal	timo	re				1 Yes 2 No
Maryl r 28a-f	Director	10e. Street and Number	0		Zip Code	<u></u>	10g	Citizen of What Cou	•
eath with the Maryland items 23a or 28a-f show ust be notified at once.	a	4341 Shelto	12. Was Decedent Ever in U.S.		2/20		ecify Yes or No-		rican Indian, Black,
P 9 8	y Funeral	1 Never Married 2 Marr	A T 2		ecify Cuban, Me			White, etc. Specify: BL	
hours a	ed b	15. Decedent's Education (Specify		Decedent's Usu during most of v				6b. Kind of Business/	
36 thin 72 te. than "	Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+)	Sti	oden	t		Educar	hon
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, La	' / /		18.N	other's Name	(First, Middle, Ma		í
121 d be fi fental I narked	8	Edwin /Ru 19a. Informant's Name/Relationship		h Marilian Adda		Chris		Middle er, City or Town, State	
MD 2 d 2 shoul lth and M n 27 is n]٤	Edwin Trusc		/	helton		-	alte. Md	21206
re, N 1 and Health fitem	ı	20a. Method of Disposition 1 Burial 2 Cremation	20b. Place	of Disposition (N	Name of cemete		Date :	20c. Location - City or	Town, State
Pages nent of ant: I		4 Donation 5 Other Spec	Nemoval IIdin State	1 1 1	exan Cena	eter 4	116/07	owingsmi	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Si nature of Fundral Service Li	heller	1639	nd Address of F N. BRA	adury	Balte. 1	nd-21213	hapel RC
Physician /Medical	1	23a. Part I Enter the dispesse, or co failure. List only of e cause on	- '	ot enter the mod	te of dying, such	h as cardiac or	respiratory arres	, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Seizure disorder Due to (or as a consequence of):						Death
		Sequentially list conditions,	b						
	E.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):						
60, ate be executed hysician and e burial - transit	I Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): d.		-				
60, ate be exe hysician a e burial -	ğ	X UNPENDED	□ 4#2538,27,perME, G867		tT				
68760, certificate be executed nding physician and	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy 1 Live birth	Fetal dea	th 3 E	Ectopic pregnar	псу	23d. Date of deliver Month	TY Day Year
	sician/Medical	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of death Unknown	5 Other (S					
that the dened by the detached is	튄		9 Unknown s contributing to death but not resulting	ng in the underly	ing cause giver	ı in Part I.	23e. Did toba	acco use contribute to	the cause of death?
, P.(a p						1 Yes	2 No 3 Pro	bably 4 🗹 Unknown
Division of Vital Records, P.O. (a) or Attending Physician: The law requires that the rasher death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
tal Reco cian: The law certificate has	Ē						perform 1 V Yes 2		es 2 No
Vital Rec ysician: The l his certificate l director, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth	Death (Check o			
n of Vi'ding Physical. After this funeral directions	유	1 ✓ Yes 2 No 27. Manner of Death	I Inpatient 2 ENO	Outpatient 3 Time of Injury	DOA 28c. Injury at		28d. Describe ho	esidence 6 🗸 Othe	er: Scene
OD C ending sath. or: Af	Certification:	1 X Natural 5 Pending	9		1 Yes	2 No			
ivisi or Att after de Direct in by	<u> [</u>	2 Accident Investig 3 Suicide 6 Could r	ot be 28e. Place of Injury - At home, fa	arm, street, facto	ory, office buildi	ing, etc.	28f. Location (Str or Town, Sta		ural Route Number, City
Dispital hours a filled	S E	4 Homicide determine 29a. Certifying Physics	(GP cony)						
Division of Vital Records, P.O. Box within 24 hours after death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the arte completely filled in by the funeral director, page 2 should be detached for unplied by the filled in by the funeral director, page 2 should be detached for unplied by the funeral director, page 2 should be detached for unplied by the funeral director, page 2 should be detached for unplied by the funeral director, page 2 should be detached for unplied by the funeral director, page 2 should be detached for unplied by the funeral director, page 2 should be detached for unplied by the funeral director, page 2 should be detached for unplied by the funeral director, page 3 should be detached for unplied by the funeral director, page 3 should be detached for the funeral director for the funeral director for the funeral director, page 3 should be detached for the funeral director for funeral director for the funeral director for the funeral direct	Medical	(Check only	sician: To the best of my knowledge, de ner:On the basis of examination and/or i						
wit To	影	29b. Signature and title of certifier	and manner stated.		29c. License nu			29d. Date signed (Mo	
By B.		auels			O.C.M.E	Ξ.		April 9, 2007	
18 m			no completed cause of death (Item 23a) tant Medical Examiner 111	Penn Street	. Baltimore	MD 21201			
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	- 1	D				
Registr		APR 12	2007 Reserve J.	Marie					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Year APRIL

3. Time of Death

Funeral Director

1 - For State Registrar

Physician 10:46 ACQUELINE 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE CITY BALTIMORE UNIVERSITY OF MAKYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. Months 1 M 2 F Hours 24-76-8329 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Was Decedent Ever in U.S Armed Forces? Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Never Married 2☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) of Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, renne 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 1 Burial 2 Cremation 3 ☐Removal from State 11 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part1. Enter me disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 100944 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Was a. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death uneral Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19760 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH GREENESTREET, BANIMURE, M. 2/201 Dept. of Internal Wedicine 31. Date file (Month, Day, Year) 32 Registrar's Signature State APR 12 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 5:45 APRIL 15e11 Woolridge Annie 2007 /Medical 4a. Facility Name (If not institution, give street and number) 46. City, Town, or Location of Death Bathmore MD Examiner County of Death Johns Hopkins Bay view Care Center 21224 Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Z-Age (In yrs. last birthday) **Funeral** Days 1 M 2 D 76 37-28-7756 Director Dec IYGIN 25 Usuat Residence of Decedent 10a. State 10b. County NIA 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Eventual pernoifies at 1 Yes 2 No Director MD Baltimore with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 196616 Bayurew Lirche Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ Ho
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Ā 1 ☐ Yes 2 ☑ NO Specify: 3 ₩idowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 13 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Finer: If Item 27 Is marked of ()SCar 2 Williebell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Terguson hurchulle, Mi assandra more. 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Hamportant: If Ite any injury or ot once. cemetery, crematory or other place) 1 Desurial 2 Cremation 3 Removal from State Baptist Cemetery Sharon -15-07 umberland, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 914 S. Main St 23a Part1. Erier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Farmuille, VA 23901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** lure Keral tau /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Month 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 3 Probably 4 Tunknown 1 ☐ Yes 2 ☐ No Decubitus ulcer of the Saerum rector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ivision of Vital 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ₽ 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö To the Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

Johns Hopking Sunview Care

31. Date filed (Month, Day, Year)

APR 1 2 2007

32. Regist

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Center

32. Registrar's Signature

29c. License numbe

5505 Hapkins 184

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician an 8,200 /Medical 4c. County of Death 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death Examiner · Fores ark 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Ves 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 212 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 √es 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be ပ a719a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forest Park Ave. at son -WIFE 3904 Bacto, md, 21207 mabe W. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Daurial 2 □ Cremation 3 Removal from State Owing miles 4 Donation / 5 Other (Specify) 21. Signature of Funeral Service/Licens 22. Name and Address of Facility FredHILTON al three Balto, md, 2,229 Var 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or reart failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) disease Physician ere /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Due to for as Examiner 2 burial-transi and Due to (or as a consequence of): Box 68760, physician arkinson pe Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached i 9 I Inknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ di sease 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed SA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral o 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred P Hospital or Attending P 24 hours after death.
Funeral Director: After t After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1465 M-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tay a Shree A who TH HC 150 ayash 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of	Marylan		artment <i>tificate</i>			and M	lental Hy	giene	007	11663	}
	1 10 100		1. Decedent's Name (First, Middle, Las	t)			7.				2. Date of Dea		Year	3. Time of Death	
	Physici /Medic		Deirdre LaShaw								April	<u>10</u>	2007	12:10 a N	1
	Examin	er	4a. Facility Name (If not institution, give				4b. City, To			f Death			County of Deal		
			Prince Georges Ho 5. Social Security Number 6. Se		Age (In yrs.	last birthdav)	If Under 1		7ille	24 Hrs.	8. Date of Birt			Georges	ממ
	Funeral Director			□M 2【 X F	36	Yrs.		Days	Hours	Min.	NOV 14	y, Year)		thplace (State or Foreig ountry) MD	9.7
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	the M 28a-f	Funeral Director	MD Prince G	eorges	DIS	trict	10f. Zip C					10a. Citiz	en of What Co		
	3a or	I Di	1302 Waterford Dr.	ive			2074						JSA	,	
	deatl	ner	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13. V		nt of Hi	spanic Orig	gin? (Spe	ecify Yes or No-		4. Race - Ame		
36	or Ite	y Fu	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 If Yes, Give	⊠ No		1 ☐ Yes 2		Specify:	, 1 40110	rican, etc.)		Black, Whit Specify: D1		
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examiner must be molified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Date	es:	162 Dagge	lant's Havel	Ogguina	tion				d of Business	.ack	
7.	n "na	Completed	(Specify only highest gra-	de completed)	(.)	(Give	lent's Usual kind of work DO NOT use	done a	luring most)	of worki	ng	TOD. KIN	d of business	industry	
212	e filed within al Hygiene. I other than "	Com	Elementary/Secondary (0-12)	College (1-4 5+	or 5+)	Veter	inary	Med	lical	Off:	icer	Fede	eral Go	vernment	
	al Hy d oth	Be (17. Father's Name (First, Middle, Last)						18. Mothe		(First, Middle,				
yla	ould I Men Parke	To	George Albert	Watson	, Jr.				Lee		ıdrey		nonds		
Maryland	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (7		مدماده						l Route Numbe	-			
	Heal Heal tem 2		George A. Watson, 20a. Method of Disposition	Jr I	20b. P	lace of Dispo	sition (Name	of			Distric		LENES ation - City or		
OE .	Pages ent of nt: If I		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ate	_{emetery, cren} ro Cre	•		·	4/11	/2007	Ral t	imore,	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any figury or other traumatic event, the Madical Examiner must be notified at proce.		21. Signature of Funeral Service-Licen- Staven												
<u> </u>	90 E E B) X		Tallis	-	299 Fr	cede	rick	Road	of Mar	imore	, Inc.	21228	
27	*		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that cau	sed the death h line.	n. Do not ente	er the mode	of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death	
1 . SE	Physician		Immediate Cause (Final disease or condition resulting in death)	a Acqu	greek	Linn	urech	24/2	tever	190	move	me	-	Syenr	5
· Ba	/Medical Examiner		Toolating in douting	Due to (or	as a consequ	uence of):			()		,			0	
		e_	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	uence of):									
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ó,	sate be executed obysicien and the burial-transit		resulting in death) Last		as a consequ	uence of):									
8760,	cate b ohysic the b	Physician/Medical	•	d											
9 X	that the death certifica ed by the attending ph detached for use as th	/Me	IF FEMALE:	23c. If yes, outco	me of pregna	ncv						20	Para of dal		
Вох	death atten	cian	23b. Was decedent pregnant in the past 12 months? 1 🗆 Yes 2 No	1 Live birt	n 2 ⊡Fetal It at time of de	death 3	Ectopic pred Other (spec					2.	3d. Date of del Month	Day Year	
P. O.	t the c by the	hysi	9 Unknown	9 Unknow	n										
	res tha signed be det	by P	Part II. Other significant conditions co	ontributing to deal	th but not rest	ulting in the ur	nderlying cau	ise give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?	
ord	w requir been si should?										1 🗆 Y	es 2	(√io 3 □ Pr	obably 4 Unknown	1
ec	elawr hasbe	Completed									24a. Was autop	sy	prior to	utopsy findings available completion of cause of	ө
E H	ician: The certificate rector, pag										perfor	2 No	death?	20 (No	
ž	siciar cartif irecto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		5D/O		Othe			(Check only or				
Division of Vital Records,	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of		c. Injury Work	4 🗀 Nui		ne 5 🗌 Resid			cify)	-
<u>io</u>	ttending f death. tor: After the funer	atio	2 ☐ Accident 5 ☐ Pending investigation	(Month,	Day Year)	Injury	М		? /es 2 □ N	10					
ĭ≥	er de recto	ertification:	3 Suicide 6 Could not be determined	280. Place of	Injury - At ho	ome, farm, stre	eet, factory, o	office		- 4	28f. Location (S City or Tow	itreet and	Number or Ru	ural Route Number,	
	ital o urs aft ral Di	0													
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and To the Funeral Director: After this certificate has been signed by the attending physicien and compistely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier Certifying Physics (Check only one)	ysician: To the be iner. On the basi and manner	s of examinal	wledge, death lion and/or inv	occurred at restigation, in	the tim	e, date and inion, deat	d place, a	and due to the o	ause(s) a date and p	and manner as place, and due	s stated. to the cause(s)	
	To th within To th	Me	29b. Signatuse and title of certifier		11.11		29c. l		number	400-			signed (Mont		
)			> Zeuge fell	un)	(VVI)			1)5	129	8	1	Apr.	1110,	2007	
	3		30. Name and addr as of per on who o	ompleted cause		1	- h		400			L 1 \$	1700	2007 170	
			31. Date filed (Month, Day, Year)	32 800	istrar's Signa	(Eust	1-11	ve,	H LEC	101	ceine 11	Im	101		
	Sta		(Je. 1109	4 51911ar										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:00 A M Wallace 2007 Curtis Woods 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Doctor's Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) March 22, Lanham Prince George's 5. Social Security Number Birthplace (State or Foreign Country) XXM 2□F 218-34-5189 1938 Maryland Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Prince George's Beltsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4513 Greenwood Road 20705 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Tho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Feed Processor Dept. of Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lawrence Woods Mary Elizabeth Pardoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angeline Woods/Wife 4513 Greenwood Road, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/13/2007 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 22. Name and Address of Facility Donaldson Funeral Home, PA. 21. Signature of Funeral Service Licenses 313 Talbott Avenue, Laurel, MD MILO M01103 23a. Part1. Enfet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE CUNG Due to (or as a consequence of): Saquerially let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BLOCK HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown CRONARY ARTERY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? DIABETES 1 Yes 1 ☐ Yes 2 ▼ No 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1-Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury al Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Physician /Medical Examiner anding physician and use as the burial-transit Box 68760, The law requires that the death certificate be been signed by the a Division of Vital Records, certificate has lirector, page 2 s Attending Physician: director this After thi after death. in by the ŏ within 24 hours at To the Funeral C Hospital To the

Physician

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Important: If ite
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with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

llyia

KENIL WORTH AVE
Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REVA GILL M.D.

APR 1 2 2007



SUITE

29c. License number

D0050951

2400

29d. Date signed (Month, Day, Year)

RIVERDALE MD 2073/

419167

			1 - For State Registrar	State of Marylan	-	rtment of F		d Mental Hy	/giene Reg. No.	007	11665
	Discontinu		1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physici Medic/		REMBERT E	WILSON	J 1	2		03	न्।	2007	8 10 AM
1	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, o				ounty of Death	
				WITTST HOSPI			14 PA		1 1		SOMERY
	Funeral		5. Social Security Number 6. Sex 578-34-0827	7. Age (In yrs.	Yrs.	If Under 1 Year Months Days		vin. (Month, D	ay, Year)	Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent	70				May 16	<u>, 1928</u>	FIOI.	Iua
	/land		10a. State 10b. County	10c. Cit	y, Town or Loc	ation					10d. Inside City Limits
	Man	to	MD P.G.	Ri	verdale	2					1 ☐ Yes 2 ☐ No
	h the	irec	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	intry?
	15 wil	Funeral Director	4903 Oglethorpe S	treet		20737			USA		
	ems	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. W	as Decedent of h	Hispanic Origin'	? (Specify Yes or Nuerto Rican, etc.)	0- 14	. Race - Ameri Black, White,	
36	or It	y F.	1 Never Married 2 Married	1 XYes 2 No 3-2 If Yes, Give Year or Dates 0 2-1	45 /0 1	☐Yes 2011No		,	1	necify:	
21215-0036	72 hours after death with the Maryland natural; or thems 23s or 28s-f ehow dical Examirae must be notitled at	d by	3 ☐ Widowed 4 ☐ Divorced						10h Kind		White
7	n 72 nat	Completed	15. Decedent's Educ (Specify only highest grade		(Give k	ent's Usual Occup ind of work done O NOT use retire	during most of	working	160. Kind	of Business/Ir	ndustry
12	withi ene. than	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		r Reade	*		Gas	Compar	ıv
0	Hygi Hygi other		17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle			<u> </u>
a	lid be lental ked ked	To Be	Rembert Elton Wil	son, Sr.			Sue	May DeLoa	ich		
Maryland	should be mad be made be mad	Γ.	19a. Informant's Name/Relationship (Type	ре, Print)	19b. Mailing	Address (Street	and Number o	r Rural Route Numi	ber, City or 7	own, State, Zi	p Code)
Σ	and 2 selth a n 27 I		Earlene S. Wilson	- Wife	4903 (Oglethor	pe St.	Riverdal	e, MD	20737	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		Place of Disposi cemetery, crema	ition (Name of atory or other pla	сө)	Date	20c. Loca	ition - City or T	own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23e or 28e-1 show amortent: If item 27 is marked other than "natural; or items 23e or 28e-1 show amorten in items and items are notified at appreciately only or other treumatic event, the Medical Examinat must be notified at appear.		4 Donation 5 Other (Specify)		nson Fa	mily Cer	m. 4-	-5 - 07	Glad	stone,	VA
Salt	Depertiment Import Import In In In In In In In In In In In In In		21. Signature of Funeral Service License	ie \	22. Ro	Name and Addre	ss of Facility Funeral	Home			
	₫ D = 6 0		July Co	nale	P.	O. Box	6 Appo	mattox, V		522	
			23a. Part1. Anter the disease, or compli- shock, or heart failure. List only or	e cause on each line.	n. Do not enter	r the mode of dyll	ng, such as car	diac of respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	ARTERIC	SCLE	ROTIC	HEAL	KT DI	SEAS	E	
	/Medical Examiner		Tooling in dollar,	Due to (or as a conseq	uence of):						
н		-	Sequentially list conditions.). Due to (or as a conseq	uence of):						
	uted 1 Insit	듣	Cause (Disease or injury								
Ć	exection and and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
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9	ng ph as th	Jed	IF FEMALE:								
Вох	leath certific attending pl	an/l	23b. Was decedent pregnant 2	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	y		23	d. Date of deliv	
O.	e dea the at ned fo	slcl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown	eath 5 🗌	Other (specify)				Month	Day Year
P.O.	that the de led by the a detached t		Part II. Other significant conditions con	tributing to death but not res	ulting in the une	doshina sausa au	on in Part I	23a Did	tobacco use	contribute to t	the cause of death?
ds,	signed signed d be del	1 by	Tax II. Othor digitilional contact of	moding to double but not not	alting in the diff	aony arg oadao ga	roman and a		Yes 2		1
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E		e Co	25. Was case referred to medical				22.51 /	1 ☐ Yes	57740	1 🗆 Yes	20 No
⋚	Physiclen: r this certific ral director,	8	examiner?	ospital: 1 Inpatient 2	EP/Outpatient	3□ DOA Ott	or	Death (Check only ng Home 5 TRes		Other (Speci	(6 ₄)
0	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inju		28d. Describe			'97
Ö	Attending r death. ector: After by the funer	atlo	1 Accident 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk?]Yes 2 □No				
Division of Vital Records,	il or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif		et, factory, office			(Street and I	Number or Rur	al Route Number,
0	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Cer									
	Hospital 24 hours a Funeral C letely filled	edical	(Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examina	wledge, death tion and/or inve	occurred at the tilestigation, in my o	me, date and pi opinion, death o	lace, and due to the occurred at the time	e cause(s) ar , date and p	nd manner as : lace, and due t	stated. to the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	Med	one) 29b. Signature and title of confifier	and manner stated.		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
	F 3 F 8			8 mo				2	(D)	3/2/	12002
	. 1		30. Name and address of person who co	moleted cause of death (leas	n 23a) /Tvaa P	rint)	W > 11 (U		3/ 3/	/
	10		ROSS SWITH	ES WASI	LINGT	ON AD	VENTI	ST HOSP	ITAL;	TAKOM,	/2007 A PARK, MD
4.00	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	- 10					
	Registr	ar	APR 1 2 20	101 Deserses .	D. Jago						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** 12:08 PM Watkins ohn 8 2007 Apri /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore University of Maryland
5. Social Security Number 6. Sex Mudical Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months 1**∑**M 2□ F MD 56 Director 11-17-1950 212-58-5680 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 √Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1226 Treeleaf Ct 21202 USA Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1XX Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) IIth grade and Mental Hygiene. College (1-4or 5+) N A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Watkins, Susie Anderson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health ar Important: If Item 27 Is any injury or other trauones. Sandra Watkins-Daughter 3939 Greenmount Avenue Balto, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Carmel Cem 4-13-2007 Balto, MD 21. Signature of Fune | Service Licensee 22. Name and Address of Facility March F/H East 3 ren Mile Balto, Md 21202 1101 E. North Avenue Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** teart Failure /Medical Due to (or as a consequence of): **Examiner** Due to (or as a o Insequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the aftending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ renal dispasa 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To hours after death.

Ineral Director: After this
y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours at To the Funeral D completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 D 15053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Davidson MD Elan Baltomore, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

0

State

To the h

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 1 2 2007

Wordmald m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

Baltmore

Physreran

29c. License number

D47/05

29d. Date signed (Month, Day, Year)

12007

			1 - For State Registrar	State of Maryl	-	artment of rtificate of			giene 007	11668		
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Year	3. Time of Death 9:35 AM		
	/Medio		Christine F. 4a. Facility Name (If not institution, give s	Wisner treet and number)		4b. City, Town.	or Location of D		4c. County of Death	1/33 /		
	Exami	ier.	Keswick Multicare	·		Balti			N/A			
	Funeral Director		5. Social Security Number 6. Sex		yrs. last birthday) Yrs.	If Under 1 Yea Months Day	r If Under 24 I	Hrs. 8. Date of Birt Min. (Month, Da Jan. 16	h 9. Birthi	place (State or Foreign ntry) land		
land	Mo II		10a. State 10b. County	10c	. City, Town or Lo	ocation				0d. Inside City Limits		
е Маг	ta lat	ctor	Maryland N/A]	Baltimor	e				MXYes 2 □ No		
death with the Maryland	s or 28	Funeral Director	10e. Street and Number 700 W. 40th Street	- Vograigle M	11+i aara	10f. Zip Code	21211		10g. Citizen of What Coul	ntry?		
leath .	ne 23. must	erai		2. Was Decedent Ever i				? (Specify Yes or No- uerto Rican, etc.)	USA 14. Race - Americ	can Indian,		
Z15-0036 thin 72 hours efter o	rei', or itema 23a or 28a-l ahow Exemirar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		If Yes, specify Cu		uèrto Rican, etc.)		etc. ite		
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N 5	other ent, I	a)	10 17. Father's Name (First, Middle, Last)		110	menaker	18. Mother's	Name (First, Middle,		e		
yland	Menta irked itic av	To B	Walter Herion				Anna	a Leutner				
2 sh	f Heelth and M Item 27 is mar other traumat		19a. Informant's Name/Relationship (Typ	pe, Print)					er, City or Town, State, Zip	Code)		
C -	f Heelth item 27 other tr	L	Ronald E. Wisner 20a. Method of Disposition	Son 20	b. Place of Dispo	osition (Name of		Seaford	DE 19973 20c. Location - City or To	own. State		
Pages	0		1 ☐ Burial 2☐ Cremation 3 ☐ Re 4 ☐ Donation, 5 ☐ Other (Specify)	1	cemetery, cre	matory or other pi rematory		12/2007	Catonsville			
Baltimore,	Department important: if any injury or gode.		21. Signature of Funeral Service License	0 /	2:	Name and Add	ress of Facility					
ă ă			herm B.	Henss	/ B	urgee-He 631 Fall	enss-Seit s Road,	tz Funeral Baltimore	Home, Inc.	21211		
Phy	ysician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on timmediate Cause (Final disease or condition	cations that caused the ce cause on each line.	teath Do not en	ter the mode of de	ring erich se carr	diac or respiratory ar Malowas C	roet	Approximate Interval Between Onset and Death		
	Medical aminer		resulting in death)	Due to (or as a con	sequence of):			d	idease			
	*	-e	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):							
/ petn:	d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events									
be executed	sician and burial-transit		resulting in death) Last	Due to (or as a con	sequence of):							
8/00 cate be	> 0	dicai	€ d									
. BOX 08/	ettending ph I for use as th	/Me	IF FEMALE:	Sc. If yes, outcome of pre	agnancy				23d. Date of delive	25/		
	y the etter sched for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□Ectopic pregnan □ Other (specify)	су		Month	Day Year		
ecords, F.O.	been signed by the ette should be detached for	by	The significant containing to death but not resulting in the underlying cause given in Part 1.							ne cause of death?		
PCO Pw re	as bee	Completed						24a. Was autop		psy findings available impletion of cause of		
T Light	certificate has rector, page 2	Соп						perfor	rmed? death? 2	2 □ No		
Of VITAL Physician; 1		o Be	25. Was case referred to medical examiner?	ospital:		- 10	ithor	Death (Check only or				
o F	윤교	H-18	1 Yes 2 No	1 ☐ Inpatient : 28a. Date of Injury (Month, Day Yea	2 ☐ ER/Outpatier 28b. Time o	11 3LI DOA	4 Nursin		lence 6 ☐Other (Specificow injury occurred	y)		
IVISION r Attending	er death. •ctor: After th by the funeral	ation	1	(Month, Day Yea	r) Injury		ork? ⊒Yes 2⊡No					
DIVIS tal or Attu	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
e Hospi	within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	icien: To the best of my er: On the basis of exan and manner stated.	knowledge, deat nination and/or in	h occurred at the vestigation, in my	time, date and pl opinion, death o	lace, and due to the occurred at the time, o	cause(s) and manner as s date and place, and due to	tated. the cause(s)		
To th	To th comp	Me	29b. Signature and title of certifier	A Anna	MO		nse number		29d. Date signed (Month,			
			▶ 7. Sebelle VIA	gregu	riy)	0/	3657		april 9, 2	007		
6	}			npleted cause of death (Item 23a) (Type,) 700 b	Print) 404	h STRE	ET, BALI	0.70 212	11		
TE.	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 20	32. Aggistrar's Si	ignature	1-0-						

DHMH 17 Rev 1/2001

		•	for State Registrar	State of Ma		epartment of He Ce <i>rtificate of D</i>		_	giene	7	11669	
ı	⁵ Physicia	an	1. Decedent's Name (First, Middle, I	.ast)	+			2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic	al	Scholley	Webb	UR		((B	4-	5 - 2	2007	4:15 PM	
	Examin	er	4a. Facility Name (If not institution, g			4b. City, Town, or I			4c. County	LTIMO:	DΕ	
	Funeral		CATONSVILLE COM 5. Social Security Number 6		e (In yrs. last birth	BALTIM If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da			ace (State or Foreign	
	Director		214-12-2470	1 ⊠ M 2□F	88 Y	rs. Months Days	Hours Min.	MAY 28	1918	MARY.		
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits	
	farylan som	٥									1 ☐ Yes 2 XNo	
	the N	Director	MARYLAND BALTI 10e. Street and Number	MORE	C.	ATONSVILLE 10f. Zip Code			10g. Citizen of V	What Count	try?	
	death with the Maryland ms 23a or 28a-f show		176 WINTERS LA	NE		2122	.8		U.S.A			
		Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Sp.	ecify Yes or No Rican, etc.)	- 14. Rac	e - America		
20	within 72 hours after death with the Maryla ene. than "natural", or Items 23a or 28a-f shov the Medical Examinations; be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 XXVidowed 4 ☐ Divorced	1 NYes 2 N		1 ☐ Yes 2 ☒ No	Specify:		Specify			
215-0036	hour tural	ed b	15. Decedent's	Year or Dates:		Decedent's Usual Occupa	tion		16b. Kind of Bi			
ÿ	nin 72 In na	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5		Decedent's Usual Occupa 'Give kind of work done du life. DO NOT use retired)	uring most of work	ring			E COMMUNITY	
717	× 6 4 2	Com	11th grade	College (1-401 3		AINTENANCE E	NGINEER		COLL		E COMMONIII	
and	be filed htal Hygi ed other avant, II	Be (17. Father's Name (First, Middle, La				18. Mother's Name		, Maiden Suman	ne)		
<u>Ya</u>	should Ind Menion Menion	ို	SCHOLLEY WEBB S				ADA T					
Z	d 2 sh th and 7 ia n traun		19a. Informant's Name/Relationship			Mailing Address <i>(Street al</i> 5 Winters La				City or Town, State, Zip Code)		
	es 1 and 2 should bof Health and Ment itam 27 is marked rother traumatic s		Iris E. Hebron/ 20a Method of Disposition		20b. Place of	Disposition (Name of		Date	20c. Location -		wn, State	
<u> </u>	y o		1 Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe	Removal from State	1	r, crematory or other place SON FOREST	1	6-07	OWINGS	MTTT	S. MD.	
ваштоге,	permit. F Departme Importar any injur		21. Signature of Funeral Service Lic	4	0.11.11.	22. Name and Address	s of Facility					
ш	20599		Jaloun	6/2		1206 W. NO	RTH_AVEN	UE			Approximate	
			23a. arti. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly of e cause on each lin	10.	A conservation mode of dying	, such as cardiac	or respiratory a	nest,		Interval Between Onset and Death	
	Priysician / /Medical		disease or condition resulting in death)	a. Aaua	nceg c	tementia						
	Examiner			ì	a consequence c	,,,						
	n =	ner	Sequentially list conditions, by learning the cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence o	n:						
V	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence o	Α.						
ρΩ,	ificate be executed g physician and as the burial-transit	ai E	500 (5) (6) 45 2 5511554351165 51).									
P8/P0	tificate ng phys as the	edicai		d			-					
XOP	death certifii e attending p id for use as	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetel death	3 □Ectopic pregnancy				te of deliver	,	
	0 0	Physician/M	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at 9☐ Unknown		5 ☐ Other (specify)			Мо	nth	Day Year	
J.	requires that the de een signed by the a hould be detached i	Phy	9 ☐ Unknown Part II. Other significant conditions		ut not reculting in	the underhand eques and	n in Part I	23e Did t	obacco use cont	ribute to the	e cause of death?	
ďS,	ires that signed b	3 by	Patti. Other significant conditions	Contributing to death be	at not resulting in	are underlying cause give	((III F (0) () .	1 🗆 1	. /		ably 4 □Unknown	
cord	> D 10	ietec						24a. Was	an 24h	Were auton	osy findings available	
ĕ	e lar has	Completed				-		autor perfo	psy ormed?	prior to com death?	npletion of cause of	
VITal		a	25. Was case referred to nedical				26. Place of Deat	1 ☐ Yes		1 🗆 Yes	2 🗆 NO	
	S S	To B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ER/Out	patient 3 DOA Other	r: 4 ursing Ho	ome 5 🗆 Resi	dence 6 Oth	er (Specify)	
n or			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b. Ti	jury Work'	?	28d. Describe	how injury occur	red		
<u> </u>	or Attanding after death. Diractor: After in by the fune	cati	2 Accident investigat 3 Suicide 6 Could no	he			′es 2□No	19f Logation /	Stroot and Numb	or or Pural	Dauta Number	
DIVISION	after of Dirac	Certification:	4 Homicide determine	building, etc	ory - At nome, far c. (Specify)	m, street, factory, office		City or To	Street and Numb wn, State)	er or nurar	Houle Number,	
	To tha Hospital or Attand within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical C			examination and	death occurred at the time for investigation, in my op-						
	To tha h within 24 To the f complet	Me	29b. Signature and title of certifier	1(N)		29c. License	number		29d. Date signe	d (Month, L	Day, Year)	
			bulling	week.	MD, MI	PH DO	05641	4	4-6	-20	007 007 0,MD 2/28	
	2+1		30. Name and address of person wh	o complete cause of de	eath (Item 23a) (Type, Print)	n. n.	0.440	0-115		110	
			31. Date filed (Month, Day, Year)	32 Radion	ar's Signature	16 tusti	ng Hvel	nue,	Da/11	nore	CIN TO	
	Sta Registr		APR 1	2 2007	Reserve St.	Coules					$\alpha/p(\alpha)$	

Physician /Medical Examiner

For State Registrar	State of	f Maryland		artment			and M	lental Hy	•	20	n 7	1.16	570
Registrar 1. Decedent's Name (First, Middle)	e, Last)			rimoatt	01 2			2. Date of D			0 1	3. Time of	Death
Timothy Edward	d William	s						April	7,	^D 2007	Year	1:15	Рм
4a. Facility Name (If not institution Stella Maris Ho		nber)		4b. City, Luth		Location o	of Death			4c. County	of Death imore		
5. Social Security Number 219–78–0744	6. Sex 1 ⊠ M 2□ F	7. Age (In yrs. I 46	ast birthday, Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 07/06)	irth Pay, Ye 119	ear) 60	9. Birthp Coun Mary	place (State of ntry) Land	or Foreign
Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation							1	0d. Inside C	ity Limits
Maryland Harfor	rd.	Ab	ingdor	n								1 ☐ Yes	2 🔀 No
10e. Street and Number			-	10f. Zip					_	Citizen of \	What Cour	ntry?	
3715 Longley Ro			110	210			-1-0 (0-			.S.A.	e - Americ	on Indian	
11. Marital Status 1 □ Never Married 2 □ Mari 3 □ Widowed 4 ♣ ♣ vivorced	ried Armed Fo	2 ⊠X o ⁄e	5. 13.	If Yes, spec		spanic On n, Mexicar Specify:		ecify Yes or N Rican, etc.)	10-		ck, White,	etc.	
15. Deceden	it's Education st grade completed)		(Give	edent's Usua e kind of wor	rk done c	luring mos	t of work	ing	16b	. Kind of B	usiness/Ind	dustry	
Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT us) -			_T	andsc	ani na	7	
12 17. Father's Name (<i>First, Middle</i> ,	Last)		Sup	ervisc)T.	18. Mothe	er's Name	e (First, Middle					
Lawrence Homer	Williams		T		10: 1		_	irginia			0	0.41	
19a. Informant's Name/Relations Almed Williams			1	_				al Route Num Baltir					20
20a. Method of Disposition		1 0	lace of Disp	osition (Nan	ne of	1		Date		c. Location			
12 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		Hol						1/2007					
21. Signature of Funeral Sector	Licensee		2	22. Name an 1 407 (^{id Addres} B r l Old E	s of Facili 12dzi 2aste:	nski rn A	Funera venue,	al I Es	Home, sex, 1	P.A. Maryl	and 21	1221
a Part1. Expert e disease, o shoot in heart failure. List Immedi Cause (Final disease indition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Expert Libertly Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to	aused the death arch line. AL CELL (or as a consequence of the conseq	CANCE uence of):		e or dym	g, such as	cardiac	ог гезрпаюту	arrest			Approxima Interval Be Onset and	tween
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditi	1 □Live t 4 □ Pregr 9 □ Unkn		I death 3 eath 5	□Ectopic pr □ Other (sp	pecify)		i.			cco use con		Day the cause of	
								24a. Wa	as an		Were auto	opsy findings	available
								per 1∐ Yes	rforme 2 X	d?] No	death?	2 □ No	
25. Was case referred to medical examiner?	Hospital:		FD/6		Oth	or:		th (Check only					
1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide detern	28a. Date (Monigation not be 28e. Place		28b. Time Injury	М	28c. Injur Wor 1 🗆	v at		28d. Describe 28f. Location City or T	e how	injury occu	rred		mber,
29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the I Examiner: On the	asis of examina	wledge, dea	ath occurred investigation	at the tir	ne, date a pinion, de	ind place eath occu	, and due to the rred at the tim	ne cau	se(s) and me and place	nanner as s	stated. to the cause	(s)
29b. Signature and title of certific	_	iner stated.		29		e number	720		29d	. Date sign	ed (Month,	Day, Year)	
30. Name and address of person	n who completed cau	se of death (Iten	1 23a) (Type	e, Print)			~					`	
DR. TARIQ MAH		DULANI		LEY R	D.	TIMON	NIUM,	MD 21	093	3			
31. Date filed (Month, Day, Year	2 2007	Registrar's Signa		house.	8								
MINA	N LUUI	Part Will Gard .	F-5"	100	-								

D

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 April 6, **Physician** Alberta Wilson 5:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritage Nursing Center Dundalk Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 7, 1927 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 166 22 6648 79 Director New Jersey Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a State 10b. County 10d. Inside City Limits Maryland Baltimore Middle River 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 9903 Dehavilland Way Apt. 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Yes 2 No Maryland 21215-0036 Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be f th and Mental H Be Charles Livingston Susanna Pierce Trons permit. Pages 1 and 2 shou
Department of Health and M
Important: If Item 27 Is marl
any Injury or other traumant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susananne Dannenfelser (daughter) 105 Woodland Avenue Dundalk Maryland 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 4/9/2007 Baltimore County, Md Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. S ature of Funeral Sen 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease, or , or heart failure. List 238 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Cause (Final **Physician** diseas of condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a consecuence of Examiner attending physician and for use as the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ģ 1 🗌 Yes 2□ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has HRONIC SEASE OBSTRUC certificate 1∐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2/11/10 ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural To the record within 24 hours after deam.

To the Funeral Director: After the Funeral Director: After the Funeral Director After the Funeral Director After Total Funeral Director Dire 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

07-02705 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Joshua Joseph West State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Month Day April 9, 2007 Joshua 1423 hrs Joseph 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Jones Road at bridge over Gunpowder River White Marsh **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 1X M 2 F Country) 212-27-7243 11/9/1985 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or items 23a or 28a-f shormust be notified at once. 1 Yes 2 XNo death with the Maryland <u>Maryland</u> Baltimore Director White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11617 Jerome Avenue 21162 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12, Was Decedent Ever in U.S. 14. Race - American Indian, Black. Armed Forces? 1 X Never Married 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes 3 Widowed the Medical Examiner 4 Divorced f Yes, Give Year 1 Yes 2X No specify: ş White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed timore, MD 21215-0036
t Pages I and 2 should be filed within 72 hou ment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "nat during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Warehouse 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Joseph West Kerrie Jean Ulrick 19a. Informant's Name/Relationship (Type, Print) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph West (Father) 11617 <u>Jerome Avenue</u> White Marsh, Maryland 21162 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4/12 2007 Department or Important: I 4 Donation 5 Other Specify Bayview Crematory Baltimore, Maryland Sit nature of E 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue Maryland 21221 art I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Milure. List only one ca ise on each line Between Onset and /Medical a. Multiple Injuries Immidiate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene this DOA 1 🗸 Yes ဥ 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Hit by train 1 Natural FOUND: Pending Yes 2 🗸 No Apr 9, 2007 1353 hrs 2 🗸 Accident Investigation in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Jones Rd at bridge over Gunpowder River, White Marsh. determined (Specify) Railroad tracks Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

24 hours after death. To the Funeral Director: within 2

Medical

State Registra

30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated

111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 10, 2007

ORIGINAL

1)

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director:

> 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 29, 2007

State Registra

			State of N	laryland / De <i>C</i>	partment of F ertificate of			giene	07	11674
	4	3	Decedent's Name (First, Middle, Last)				2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Belaynesh Yigletu				March March	30,2007		12:08P ^M
1	Examin		4a. Facility Name (If not institution, give street and number	-)		r Location of Death		4c. Count	y of Death	
	255.5 30		Holy Cross Hospital		Silver				gomery	
	Funeral		10 M 057 C	nge (In yrs. last birthda 92 Yrs	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da August	h 1915	Country	
236	Director		Usual Residence of Decedent				August	30,	Ethiop	oia
	land ow It		10a. State 10b. County	10c. City, Town or	Location				10d	. Inside City Limits
	Mary fied	ţo	Maryland Montgomery	White Oa	k					XX Yes 2 No
	r 28a	irec	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Country	?
	h witi 23a o st be	a D	801 Schindler Drive		209	903				
	ems ems	Funeral Directo	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S. 1	Was Decedent of H If Yes, specify Cub.	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	. 14. Ra	ce - American ick, White, etc	
9	or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 至 If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates	1 No	1 ☐ Yes 2 ☐ No				_{fy} Ethiop	
Š	hours tural	d by	3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education		cedent's Usual Occup	agtion		16b. Kind of E	Rusiness/Indus	rtn/
2	n 72 "na"	lete	(Specify only highest grade completed)	(G	ive kind of work done	during most of work d)	king	TOD. KING OF E	Juaine 35/ maus	sti y
7.	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or None	(5+)	maker			Priva	te	
ğ	other other /ent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surna	me)	
<u>a</u>	uld bu Menta Irked Itic ev	To E	Bekel Abyu			Tesmash	Bekel -			
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Kassa Tesfaye/Son	19b. Ma 1867	channing Channing	and Number or Rui St NE, Wa	ral Route Numbershingto	on DC 2	0018	ode)
ore,	of Her		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dis	sposition (Name of crematory or other place	ce) Apri]	Date	20c. Location	- City or Town	, State
Ĕ	Pag ment ant: I		4 Donation 5 Other (Specify)	Ft Line	oln Cemete	ry 2007		Brentwo		
Bail	permit. Depart Import any Inj		21. Signatur of Funeral Service Unen de		22. Name and Addre					
	2 4	ĝ.	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not line.	enter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	A	pproximate iterval Between
	Physician			cleortic (Cardio Vas	cular Dis	ease		el C	nset and Death
1	/Medical			s a consequence of):					18	
	Examiner		Sequentially list conditions, b.	107 120					===	
(A)	ed sit	Examiner	Sequentially list conditions, new particular and pa							
_	and and Il-tran	хап	that initiated events resulting in death) Last C. Due to (or a							
8/60,	death certificate be executed e attending physician and d for use as the burial-transit	lical E								
28	ficate phys s the		d.							
ROX	leath certific attending p	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		_			23d. D	ate of delivery	
	death e atte d for	Physician/Mec	in the past 12 months? 1□Ves ※□No 4□Pregnant	at time of death	3 □Ectopic pregnanc; 5 □ Other <i>(specify)</i> _	у		M	onth Da	ay Year
J.	t the	hys	9☐Unknown							
	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death	but not resulting in the	e underlying cause giv	en in Part I.	23e. Did t	obacco use cor	tribute to the	cause of death?
D	equire en si						10'	Yes 2□No	3 ☐ Probab	ly 4 ⊠Unknown
Vital Records,	law r as be 2 sh	Completed					24a. Was auto			y findings available letion of cause of
<u> </u>	sician: The law certificate has l irector, page 2 s	Son					perfo	rmed? 2 🙀 No	death?	□No
119	clan: ertific ector,	Be (25. Was case referred to medical examiner?			26. Place of Dear	th (Check only o	nne)		
	Physi this c	우	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpa 27. Manner of Death 28a. Date of In		tient 3 DOA Oth	4 🗆 Nursing H	ome 5 Resi			
5	ding F h. After funera	ion:	1 X Natural 5 ☐ Pending (Month, D	ijury 28b. Time Pay Year) Injur	y Wor	ryat rk? Yes 2 ⊟No	28d. Describe	how injury occu	rred	
<u>s</u>	death ctor: / the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of i	njury - At home, farm,		165 2 140	28f. Location (Street and Num	ber or Rural F	Route Number.
DIVISION OF	after Direction	Certification:	4 Homicide determined building,	etc. (Specify)	,,		City or To	vn, State)	201 01 1101011	
	spita neral y fille		29a. Certifier 1 Certifying Physician: To the bes							
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detache	Medical	(Check only one) 2 Medical Examiner: On the basis and manner:		r investigation, in my o	opinion, death occu	rred at the time,	date and place	, and due to th	ne cause(s)
	To the withing the total complex complex complex to the total complex complex total co	Ž	29b. Signature and title of certifier		29c. Licens	se number		29d. Date sign	ed (Month, Da	ıy, Year)
	.^		MUL		D6429	6		March	30,200	7
	4		30. Name and address of person who completed cause of		·			0.1.6		
			Richard Nguyen M.D. 1500 F	orest Gler	Road,Sil	ver Sprin	g MD 20	AT0		
	Sta Registr		31. Date filed (Month Pay Year) APR 1 2 2007	es de A	noute of					
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07-02685 Eric Zurawski

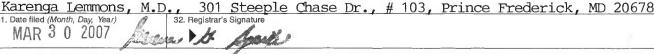
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1. December 1 Amen First Medital, and 1. December 1 Amen First M			1- For State Certificate of Death Registrar	ornar riygici	Reg. f	No. 200	17 1167
The state of the s		an/	1. Decedent's Name (First, Middle,Last)	Mor	e of Death	av Year	
Social Social Parameter Social Social Parameter Social Parameter	neuicai Exaiiii	Her	ELICK J. R. ZULAWSKI		11 8, 2007		
215-90-5938 X x z p 39	.)		University Hospital Baltimore			N/	A
The first country of the first			215-90-5938 1X M 2 F 39 Yrs. Months Days Ho	1	,	TEOROI	an l
The control of the	any						10d. Inside City Limits
1 Secretary 1 1 New Americal 2 Marine 1 New Americal 2	land f show once.	Ď					1 Yes 2 X No
Second Continues Second Cont	th the Mary 23a or 28a notified at		348 Bigley Avenue 21227			United S	tates
Section Continued Contin	er death wit or items?	Funera	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexical Never Married 2 Yes 2 X No	kican, Puerto Rican,		White, etc.	
Section Continued Contin	urs afte tu ral ",		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (G	Give kind of work do	one 16		
The filter and production of the product of the p	036 ithin 72 ho ne. r than "na ledical Ex	nplete	Elementary/Secondary (0-12) College (1-4 or 5+)			N/A	
Rebecca-Elinore Zurawski-Dau 1123 W. Hamburg Street, Baltimore, MD 21223 Zo. Location - City or Town, State 1 Date of Disposition (Name of Corretery) Date of Correct (Name of Corretery) Date of Correct (Name of Corretery) Date of Correct (Name of Correct (Na	15-0 filed will Hygie of other			•		den Surname)	
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22. Name find Address of Facility Ambroose Funeral Home, Inc. 1328 Still phur Spring Rd. Arthattus MD 21227	MD d 2 shouth and in 27 is aumati						
22. Name find Address of Facility Ambroose Funeral Home, Inc. 1328 Still phur Spring Rd. Arthattus MD 21227	more, Pages 1 an nent of Hea ant: If ite		1 Burial 2 X Cremation 3 Removal from State West Arundel 4 Donation 5 Other Specify.	4-12-2	2007	Odenton,	MD
Physician Modical Xaminer 23a. Part I. Enter the disease, or complications that caused his death. Do not enter the mode of cyting, auch as cardiac or Registratory anest, shoot, or heaft failure. Let only one cause on each inc. 3. State would of chest and neck or condition resulting in death) 5. Sequentially, ill conditions. 6. Due to (or as a consequence of): Copy of the sequence of the conditions. 6. Due to (or as a consequence of): Copy of the sequence	Balti permit. Departr Import injury		21. Signature of Funeral Service Licensee 22. Name and Address of Fa	^{acility} Ambrose	Fune	ral Home,	Inc.
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The content of the		ē	Codecimally not conditione;				-
The content of the		amin	cause Enter Underlying Cause (Disease or injury that initiated c.				
Past 12 months? Test cuted mid transit	EX	events resulting in death). Last					
Past 12 months? Test O, be exe	edica						
State 3 Suicide 4 V Homicide Could not be determined (Specify) Sidewalk Sidewalk To Town, State) 1300 block West Ostend Street, Baltimore, MD 280. Certifier (Cheek only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. April 9, 2007 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	3876 rtificate ing phy as the t	M/m	23b. Was decedent pregnant in the	ctopic pregnancy			
State 3 Suicide 4 V Homicide Could not be determined (Specify) Sidewalk Sidewalk To Town, State) 1300 block West Ostend Street, Baltimore, MD 280. Certifier (Cheek only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. April 9, 2007 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Box (e death ce the attend ted for use	hysici	1 Yes 2 No 9 Unknown 4 Pregnant at time of 5 Other (Specify)				
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Registrar NDR 1 2 700 (Language 1)			to a company to the property of				

State Registrar

31. Date filed (Month, Day, Year)
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Demunis Mp.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Belle 22 2007 8:00 Air March Edna '/Medical 4c County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Walkersville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Dec. 26, 19 Glade Valley Nursing Home Frederick 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** New York 1□ M 2√XF 1919 084-18-0278 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 5820Genisis Lane 21703 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 📉 No Specify: White þ ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) 2 should be fill and Mental H Edna Belle Braren Joseph Havilend McCloskey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 10 Washington St. Middletown, Maryland 21769 Kevin Air / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or 3/31/2007 Baltimore, Marvland Baltimore Crematory 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Annapolis, MD 21401 147 Duke of Gloucester St. 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a const uence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ng physician and as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2□ No 2 No I or Attending Physician: after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 ☐ Accident I Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) Name a AVE FREDERICK ND 21702

State Registrar MAR 2 8 200

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1475 MD Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month Year **Physician** PM Betty Jane Bradley 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 9, 1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 ☐ M 2 🕅 F 75 578-40-1078 D. C. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. Insit; If item 27 is marked other than "natural", or items 23a or 28a-f show mix; If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Berkeley 1 X Yes 2 No W. Va. Falling Waters Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 46 Muse Street 25419 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No Specify: Completed by white Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Graves Olive Rebecca Byrum 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Recreation Lane, Falling Waters, W.Va.25419 Kimberly A. Hawbaker - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If its any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park 4/5/07 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Stem **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): revers of wheeled would pute Examiner e-10/20-1712 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical for use as the attending 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Dav 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 10 3 Probably 4 ☐ Unknown Completed peen 11, see se 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? res 22No 1∐ Yes Physiclan: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 TYes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 ☐ Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1-🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier

5H6-6

State Registrar 31. Date filed (Month, Day, Year) APR 0 3 2007

R166 65

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

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medical 32. Fegistrar's Signature 138764

55. to 127

Hegerstern

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Catherine Bragunier State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 2. Date of Death Time of Death Decedent's Name (First, Middle, Last) Physician/ April 6, 2007 1919 hrs Medical Examiner Catherine Regina Braqunier 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Days Director 1916 Merry land 212-14-6800 1 M 2 X F 91 Jan. 16, Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 X Yes 2 No Williamsport Maryland Washington Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
anti: If item 27 is marked other than "natural", or items 23a or 28a-f sho anti: If item 27 is marked other than "natural", or items 2 no r 28a-f sho anti- Item and the weat, ite Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 37 West Church Street 21795 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2 X No Yes If Yes, Give Year 3 X Widowed Divorced Yes 2xx No specify. White ≥ 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clvde Bell 19a. Informant's Name/Relationship (Type, Print) Rebecca Rockwell Sarah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Williamsport, 21795 Church St. Maryland <u> Bonnie Kirby - Daughter</u> 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) April 10,2007 Williamsport, MD Important: Greenlawn Mem. Park Bonation 5 Other Osborne P.A. e of Fune 21795 425 S. Conococheague St. Williamsport, Maryland Tart I of ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bilateral famur and right foot fractures complicating Approximate Interval Physician Between Onset and /Medical Death hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED #232.PII.27,28a-f perME, g868, 6/11/07 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö þ 1 Yes 2 No 3 Probably 4 Unknown Diabetes mellitus dementia

The law has e 2 sl Hospital or Attending Physician: of Vital this

Completed 25. Was case referred to medical Be 1 Ves 2 27. Manner of Death Natural

Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 28a. Date of Injury (Month, Day, Year) Pending 4/6/2007 2 X Accident Investigation

Could not be Suicide determined 29a. Certifier 1

(Specify) nursing home and manner stated

Assistant Medical Examiner

28c. Injury at Work? 28b. Time of Injury FNd 7:20 am 28e. Place of Injury - At home, farm, street, factory, office building, etc

DOA

1 Yes 2 X No

26.Place of Death (Check only one)

28d. Describe how injury occurred subject fell out of bed

24a. Was an

Other Nursing Home 5 Residence 6 Other

autopsy

performed? ✓ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 16505 Virginia Ave. Williamsport, MD

April 7, 2007

. death?

1 🗸 Yes

24b. Were autopsy findings available

prior to completion of cause of

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

State Registrar

To the

Medical

31. Date filed (Month PR ear) 2007

Tasha Greenberg MD.

ORIGINAL

DHMH 17 Rev 1/2001

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			1 State		artment of Health and rtificate of Death		2001	11680			
			Registrar 1. Decedent's Name (First, Middle, Last)		inicate of Death	2. Date of Death	. No.	3. Time of Death			
	Physici		Mildred Louise Beyard			March 31,	Day Year 2007	11:10A M			
	/Medic Examin		4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, or Location of Dea		4c. County of Death	11.1011			
	Lxamiii	C1 .	17809 Burnside Ave.		Hagerstown		Washingto	n			
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthp	place (State or Foreign			
	Director		219-20-0626 1□ M 2 M F	80 Yrs.	World's Days Flours Will	Sept 21,	1926 Maryl	and			
	و <u>*</u>		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ncation		1	0d. Inside City Limits			
	ehov	7	Toa. State	Too. Oity, Town of Ed	Cation			1 XYes 2 No			
	Ne M	ecto	Maryland Washington 10e. Street and Number	Hagersto	10f. Zip Code	100	. Citizen of What Cour				
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Hauth and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-1 show other traumatic event, its Medical Examiner must be notified at	Funeral Director			21740		J.S.A.	tu y ?			
	eath	erai	17809 Burnside Ave. 11. Marital Status 12. Was Dec	edent Ever in U.S. 13.	Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - Americ	can Indian,			
10	ther d	Fun	Armed F	orces?	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White,	etc.			
936	urs a	by	3 Widowed 4 ☐ Divorced If Yes, G Year or I	ve ·	1 ☐ Yes 2 🕱 No Specify:		Specify: Whit	e			
215-0036	2 ho	Completed	15. Decedent's Education (Specify only highest grade completed,		dent's Usual Occupation kind of work done during most of wo	adking 16	b. Kind of Business/In	dustry			
218	within 7 ene. then "r	ple		1-4or 5+)	DO NOT use retired)	Sixing					
21	filed within Hygiene. other ther	Con		Re	gistered Nurse		Medical_				
nd	2 should be filled within and Mental Hygiene. Is marked other then aumatic event, the Mental the Mental transmitters.	To Be	17. Father's Name (First, Middle, Last)			ame (First, Middle, Ma	*				
<u>×</u>	should nd Men marke umatic	2	Charles Raymond Mask			l Lee Reyno					
Maryland	2 sh and and is m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or F						
	1 and 2 Health tem 27 I		Matthew C. Beyard / son 20a. Method of Disposition		woodcutter Rd Co		cyland 2104 lc. Location - City or To				
0	ges It of the		1 Burial 2 □ Cremation 3 □ Removal from	State	osition (Name of matory or other place)						
Baltimore,			4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			the second secon	gerstown N				
Bal	permit. Pa Departmer Important eny injury		21. Signature of Funeral Service Licensee		2. Name and Address of Facility ${ m Re}$			•			
	402 6 0		23a. Part1. Enter the disease, or complications that		501 Pennsylvania			Approximate			
			shock, or heart failure. List only one cause on	each line.	to thou or dying, such as cardi	20 or roop natory arroo	"	Interval Between Onset and Death			
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a Urosepsis hours								
			Due to	(or as a consequence of)	- Renal Fa	Livo		Years			
н		-	Sequentially list conditions, b. Due to	(or as a consequence of):	- Resulta	Hore		/EM 5			
	nsit	пju	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	TUDO II	Diabetes			vears			
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	tificat ig phy as th) (1				
Вох	eath certif ettending for use a	an/N	23b. Was decedent pregnant	itcome of pregnancy birth 2 ☐ Fetal death 3[∃Ectopic pregnancy		23d. Date of deliv	,			
	law requires thet the death certii as been signed by the ettending 2 should be detached for use a	Physician/M	1 Yes 2 No	nant at time of death 5	Other (specify)		Month	Day Year			
P.0	res thet the de signed by the e be detached t	Phy	9 Unknown	74.40		One Did take	cco use contribute to t	ha sauga of death?			
	res th	ğ	Part II. Other significant conditions contributing to	seath but not resulting in the t	inderlying cause given in Part I.	23e. Diù (00a		pably 4 Unknown			
ord	w require been sig	ted	Hnemia		1	1 165					
Records,	has b	Completed		seep Vein T	hrombosis	24a. Was an autopsy	24b. Were auto prior to co	ppsy findings available empletion of cause of			
H	ate pag	Con	Ulcerative	. colitis		performe 1 ☐ Yes 2		2□ No			
of Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othor	eath (Check only one)					
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n C	e fe	ion	. Elitataia	of Injury onth, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	280. Describe now	injury occurred				
isi	Attending r death.	icat	2 Accident investigation 3 Suicide 6 Could not be 288 Plac	e of Injury - At home, farm, st		28f. Location (Stre	et and Number or Run	al Route Number.			
Division	after Dire	Certification:	-4 Homicide determined 200. Flat	ding, etc. (Specify)		City or Town,	State)				
	Hospital 4 hours a Funeral tely filled	aic			th occurred at the time, date and place						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical		basis of examination and/or in nner state	evestigation, in my opinion, death oc	curred at the time, date	e and place, and due t	o the cause(s)			
	To the within 2 To the complet	×	29b. Signature and title of certifier	X S	29c. License number	290	d. Date signed (Month,	Day, Year)			
			Mulle		MD00521	36	04/02/	2007			
			30. Name and address of person who completed ear	use of death (Item 23a) (Type	Print)		1 00	0 2.206			
0	H-5		KJU Ciccaren	3 byr	kut uy u	lillams	port III	U 21795			
35	Sta		31. Date filed (Month, Day, Year) 32. APR 0 3 2007	Registrar's Signature	1.11		7				
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DHMH 17 Rev 1/2001

			Tor State Registrar	State of Marylar	•	artment <i>rtificate</i>			and Me		giene Reg. No.	2007	11681
	Dharaisi		1. Decedent's Name (First, Middle, Last	0						Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Evelyn H. Benson						M		28, 2	007	3:25 A ^M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, To			f Death			County of Dear	
		d y	Casey House 5. Social Security Number 6. Se	ex 7. Age (In yrs	. last birthdav)	RO If Under 1		ille If Under 2	24 Hrs. 8	. Date of Birl	th	ntgomer	thplace (State or Foreign
	Funeral Director			□M X □F 57		Months	Days	Hours	Min	oril 9	v, Year)	Co	ountry) \\ \tand
	D.		Usual Residence of Decedent		ity, Town or Lo								
	arylar show	'n	10a. State 10b. County	_			٠,						10d. Inside City Limits 1 X Yes 2 □ No
	the M 28a-f	ecto	Maryland Prince G	eorge's		Greenb					10a. Citiz	en of What Co	ountry?
	3a or	Funeral Directo	7072 Hanover Park	way			207	70			Ü	United	l States
	death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	l Was Decede If Yes, specif			gin? (Speci	fy Yes or No)- 1	4. Race - Ame Black, Whit	erican Indian,
Maryland 21215-0036	d within 72 hours after death with the Maryland slow. Jene. Than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2		Specify:	, 1 40,10 11	carr, c.c.,	1	Specify: Bla	
2-0	72 ho natur dical	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual kind of work DO NOT use	Occupa done o	ation during most	t of working	,	16b. Kin	d of Business	/Industry
2	t be filed within 72 h ntal Hygiene. ed other than "natu event, the Medica	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	— lite.		eretirea erk)			Pog	tal Ser	mri o o
20	in the	ပ္ပ	17. Father's Name (First, Middle, Last)	4		CI	ELK	18. Mothe	r's Name (First, Middle,			.vice
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ary	should and Men s marke umatic	۲	19a. Informant's Name/Relationship (7	ype. Print)	19b. Maili	ng Address (Street a					Town, State,	Zip Code)
Σ	and 2 ealth a n 27 l		Freddie D. Benson										and 20770
ore	Pages 1 and 2 should be nent of Health and Mental int: If item 27 Is marked our; If item 27 Is marked our or other traumatic eve		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Hemovai irom State	Place of Disponentery, cre			1	Da	-		cation - City or	
Baltimore,	it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify		tropol:	itan C	rema	otory	Mar.	28, 200)7 Al	exandria	, Virginia
Ba	permit. Pages Department of Important: If it any injury or o once.		21. Signature of Funeral Service Licen	newards	Dc	onäTď™ 400 Po	V. I	Sorgwa	årdt i	Funera	l Ho	me, P.A	A. aryland 20705
1			23a. Part1. Enter the disease, or comp	plications that caused the dea								rie, ne	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	End Stage	Liver I)iseas	e						Onset and Death
1	/Medical		resulting in death)	Due to (or as a conse									
	Examiner	L	Sequentially list conditions,	b. Alcoholic	Liver (Cirrho	sis						
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a conse	rquones on.								
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89	ng ph		IF FEMALE:										_
. Box	death certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregr 1□Live birth 2□Fe	tal death 3	⊒Ectopic pre		,			2	3d. Date of de Month	livery Day Year
o.	at the dea by the a tached fo	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	☐ Other (spe	ecify)						•
٦.	that t ed by detac		Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	ınderlying ca	use give	en in Part I.		23e. Did t	tobacco u	se contribute t	o the cause of death?
Records,	w requires that s been signed k should be deta	d by								10	Yes 2	No 3∏P	robably 47 Unknown
000	aw rec s bee 2 shou	Completed								24a. Was		24b. Were a	utopsy findings available
Ä	The la	mo								auto perfo	ormed?	death?	completion of cause of 3 2 □ No
Vital	sician: The law certificate has b irector, page 2 s	Be C	25. Was case referred to medical examiner?				23		of Death (Check only			
7	Physic this ceral dire	P	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 [4 □ Nu					ecify)Hospice
Division or	ding F h. After funera	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	or 28	3c. Injur Worl	yat k? Yes 2⊡∣		3d. Describe	how injury	occurred /	
<u> S</u>	I or Attencatter death Director:	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At	home, farm, st			100 20					ural Route Number,
2	al or / s after il Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spec	oify)					City or To	wn, State)		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan	ysician: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, dea nation and/or i	th occurred a nvestigation,	at the tir in my o	ne, date ar ppinion, dea	nd place, ar ath occurre	nd due to the d at the time,	cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	0	7	1		e number	20			e signed (Mon	
	3		Cynthia 7	n milleo	mos D	0 /	100	580.	32		3	-28	2007
•			30. Name and address of person who							4.5.5			0055
			Cynthia M. William 31. Date filed (Month, Day, Year)	ms, DO 6001 32. gistrar's Sign		er Mi	11 F	Road,	Rock	ville,	Mary	yland 2	:0855
	Sta Registr		MAR 2 9 2	007	K A	mesti 1	0.5						

DHMH 17 Rev 1/2001

		ne-c	1 - State Registrar	State of Ma	aryland				ealth a	and M	F	Reg. No.	07	11682
	Physici		1. Decedent's Name (First, Middle, Last) Lillian Marie Brow	m							2. Date of Dea Month March	Day	2007	3. Time of Death 12:22 a M
	/Medio Examir		4a. Facility Name (If not institution, give st Mandrin Hospice Ho					Town, or	Location o	f Death		4c. Coun	ty of Death	
A. 100	Funeral Director		077 10 0377	7. Age	e (In yrs. ia 82	st birthday) Yrs.	If Unde Months	1 Year Days	If Under a	Min.	8. Date of Birth (Month, Day June 12	Year) 2, 1924	9. Birth Cou New	place (State or Foreign ntry) York
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Arr	ındel		Town or Lo		:k						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28s	Director	10e. Street and Number		l		10f. Zip					10g. Citizen o		ntry?
	ne 238	Funerai	9 Marbury Road	2. Was Decedent I	Ever in U.S	i. 13. V	Vas Dece		146	oin? (Spe	cify Yes or No-	14. Ra	USA ace - Ameri	can Indian.
M36	72 hours after death with the Maryland naturel', or iteme 23a or 28s-f show deal Examble must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:					Specify:	, Puerto F	cify Yes or No- Rican, etc.)	Spec	lack, White,	
21215-0036	within ene. then	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		i+)	16a. Deced (Give life. L	kind of wo	rk done a	lurin g m ost)	of workir	ng	16b. Kind of	Business/fr Home	ndustry
land	uld be filed Mental Hygi irked other ific event,	To Be C	17. Father's Name (First, Middle, Last) Clarence Hadley Ct	ıtter							(First, Middle, n Marie			
Mary	and 2 should alth and Men 27 is marke	ľ	19a. Informant's Name/Relationship (Type James Chandler Bro	e, <i>Print)</i> own/Son		19b. Mailin 9 M	g Address arbui	(Street a	and Numbe	r or Rura Seve	Route Numbe rna Par	r, City or Town	n, State, Zij 2114 6	c Code)
saitimore,	permit. Pages 1 and Department of Healt Important: If item 2 eny Injury or other 2005.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 反Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	ce	ace of Dispo metery, cren Sau Kn	natory or o	ther place	Park		h 28, 007	20c. Location Port W	•	own, State
Dalt	permit. Departri Importa eny Inju	4	21. Signature Funeral Service Chenses	(der	lar	222 B 4	Name ar PS GO	nd Addres	s of Facility Sons	s, P.	A. Sev	verna P verna P	Park F	uneral Home MD 21146
1	Pnysician		3a. Part1 Enter the disease, or complic shoot, or heart failure. List only one Immediate Cause (Final	ations that caused cause on each lin	the death.	Do not ent	er the mod	de of dying	g, such as	cardiac o	respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medica/ Examine		disease/ r condition resulting in death)	Due to (or as	a conseque	ence of):	Can	u	un					
8/60,	cate be executed by sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a		ence of):								
O. Box oa	death certifii e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic p			_			Date of deliv	ery Day Year
as, r	requires that the een signed by th hould be detache	þ	Part If. Other significant conditions conti	ributing to death bu	ut not resul	ting in the ur	nderlying (ause give	n in Part I.			bacco use co		he cause of death?
Hecords	> 41 0	Completed			- 3						24a. Was a autop perfor	med?	prior to co death?	opsy findings available impletion of cause of
	iician: The lav centificete has rector, page 2	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or	2 ₽No ne)	1 🗆 Yes	2 □ No
5	ding Phys The After this funeral di	ုင	1 Yes 2 No Ho 27. Manner of Peath 1 Natural 5 Pending 2 Accident investigation	spital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	ry :	R/Outpatien 28b. Time of Injury		28c. Injury Work	4 🗀 140	2	ne 5 Resid 8d. Describe h		ther (Special urred	m Hospice
DIVIS	s after des s after des al Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fn _f u buifding, etc	ury - At hon c. (Specify)	ne, farm, str	eet, factor	y, office	_	2	8f. Location (S City or Tow	Street and Nun n, State)	nber or Rur	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer	edicai	29a. Certifier 1 Certifying Physi (Check only one) 1 Medical Examine	cian: To the best of er: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred estigation	at the tim , in my op	e, date and inion, deat	d place, a	nd due to the d d at the time, d	cause(s) and n date and place	manner as s e, and due t	stated. o the cause(s)
	Tor	M	29b. Signature and title of certifier Cuttur	Lan	m	D	29	. License	number 53	30	6	29d. Date sign	2 6/0	,Day, Year)
	(20)		30. Name and address of person who com	POD B	1	23a) (Type,	Print)	te 3	00	An	repolis	· me	1 2,	1 y w
	Sta Registi	_	31. Date filed (Month, Day,	3 2007 Regist	r's Signatu	ure /	An	W.						

			1 - For State Registrar	State of Marylar	nd / Depa	artme		ealth an	-		0 7	11683
	Physicial		1. Decedent's Name (First, Middle, Last)						2. Date of Do		20/424	3. Time of Death
	Physici /Medi		James Greiner Cui						March	370	2007	10:55A м
	Examir	ier	4a. Facility Name (If not institution, give s			4b. City		Location of D	eath		inty of Death	Country
			Coffman Nursing Ho 5. Social Security Number 6. Sex		last birthday)	If Unde	Hage:	rstown If Under 24	Hrs. 8. Date of Bi			n County place (State or Foreign http)
	Funeral Director		189–20–4521 Usual Residence of Decedent		9 Yrs.	Months	Days	Hours N	Feb 2	4 1928	Penns	sylvania
	Maryland a-f show	stor	10a. State 10b. County Maryland Washing		ty, Town or Lo		wn				1	0d. Inside City Limits 1 X Yes 2 □ No
	or 28	Oire	10e. Street and Number			10f. Z	ip Code			10g. Citizen	of What Cour	ntry?
	ath w	rall	1304 Pennsylvania					1742			U.S.A.	- I a di -
215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Machinal Examilian in unit be mailfied at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Ameed Forces? 1 ☐ Yes 2 ☐ N 1 - 1 If Yes, Give Year or Dates: 10-1	3-45 6-47	Was Dec If Yes, sp 1 ☐ Yes	37	spanic Origin n, Mexican, P Specify:	? (Specify Yes or N luerto Rican, etc.)		Race - Americ Black, White, ecify: wh	etc.
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Us	ual Occupa	ition Jurina most of	workina	16b. Kind o	of Business/In	dustry
21	within ene.	nple.	Elementary/Secondary (0-12)	College (1-4or 5+)				luring most of		Dont	of Ed	ucation
121	lled w Hygier her th		17. Father's Name (First, Middle, Last)	5+		Prin	cipal	18 Mother's	Name (First, Middle			ucación
anc	ould be fi Mental H arked ot atic ever	Be		on CD					Mildred G		•	n
Maryland	2 should and Me is mark sumation	٩	John Francis Curra 19a. Informant's Name/Relationship (Type		19b. Maili	na Addres	ss (Street a		r Rural Route Numi			
Z	nd 2 sulth ar 27 is r trau		J. Mark Curran (se	on)	114	0 Wo	odlan	d Way	Hagerstow	n Mary	land 2	1742
Baltimore,	Pages 1 as ent of Hea nt: if item ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20b.	Place of Disponentery, crei	sition (N	ame of		Date	20c. Location	on - City or To	
Balti	permit. Page Dep_rtment o Important: If any injury or ance.		21. Signature of Funeral Service License	Zin:	1	331	Easte	rn Blv	d. N. Hag	erstow		eral Home land 21742
760,	eath certificate be executed EX Attending physician and from sit the burial-fransit The seas the burial-fransit The seas the burial-fransit The seas the burial-fransit The seas the burial-fransit The seas the burial-fransit The seas the seas the burial-fransit The seas the	Ical Examiner	23a. Part1. Enter the disease, or complishock, or art failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection) Due to (or as a consection)	uence of): Juence of): Juence of): Juence of): What Juence of): Juence of):	with the modern the mo	Ode of dying Od Cotuse	y such as can y well to held of k	respiratory of the control of the co	errest, Let Mull	en 7	Approximate interval Between Onset and Doubth 25 July 20 July 2
.O. Box 68	requires that the death certifica een signed by the attending ph hould be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morals? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 6 9 Unknown	al death 3[⊒Ectopic ⊒ Other (s	pregnancy specify)			23d.	Date of delive	
۳,	signed by detail	y Ph	Part II. Other significant conditions con	_	sulting in the u	inderlying	cause give	n in Part I.	23e. Did	tobacco use o	contribute to t	he cause of death?
rds	w require been sig should by	ed b	My tun	ile					1 🗆	Yes 2□N	o 3 Prob	pably 4 Aucknown
l Rec	The law ate has b page 2 sl	Completed by	7.						24a. Wa. auto perl 1 □ Yes		4b. Were auto prior to co leath? 1 🗌 Yes	psy findings available mpletion of cause of 2 \(\text{No} \)
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:			Othe		Death Check only			
of	T = E	- T	1 Yes 2 No	I _ Inpatient 2 _	28b. Time o		JUA	4 American	ng Home 5 ☐ Res			(y)
LO D	th. Afte	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	М	28c. Injury Work	k? Yes 2 ∐No				
Division of	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At h building, etc. (Speci		reet, facto	ory, office		28f. Location City or To	(Street and Nown, State)	umber or Rura	al Route Number,
	ne Hospital n 24 hours a ne Funeral I	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemin	ician: To the best of my kn ler: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the time	ne, date and pointon, death	place, and due to the occurred at the time	cause(s) and , date and pla	d manner as s ce, and due to	tated. o the cause(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier	. 1		2	9c. License	number		-	gned (Month,	
			STIMUEL (M	(m)			1)56	627		Mar	en 3	0,00
Q.	N 5+1		30 yame and address of person who of	itieton	Street	Print)	hut	0 20	o. How	Just.	un,	e), 2007 MD 21740
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) (APR 0 2 200	32. Pegistrar's Sign	B. Sa	ele	,		1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deat 1. Decedent's Name (First, Middle, Last) 747 AM 2007 March THELMA LORRAINE COLLINS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Baltimore Washington Hospital Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days 10/27/1933 Maryland 73 214-30-6441 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 USA 827 Dale Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ş 3 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Employee Anne Arundel County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda Thompson Joseph Thompson ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1334 Cox Cove Court Baltimore, MD 21226 Judy Collins/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 03/26/2007 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) rosc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):

Physician /Medical Examiner certificate be executed

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f sh must be notified

or items 23a

7 Is marked other than "natural", or iten traumatic event, the Medical Examiner

Department of Health an Important: If item 27 Is any Injury or other trau

Baltimore, Maryland 21215-003

202

Examiner and use as the burial-tran attending physician for use as the buria signed by the a this

Division or Vital Records, P.O. Box 68760,

1 Yes 2 No 9 Unknown	Cause (Disease or injury that initiated events	o. Diabete	s mel	uro w	in new	gan	(Oycan
23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of of 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy prior to completion of ceath? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Pressing 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Num City or Town, State) 28d. Certifier 28d. Certifier 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Num City or Town, State) 28d. Certifier 28d. Certifier 28d. Certifier 28d. Location (Street and Number or Rural Route Num City or Town, State) 28d. Certifier 28d. Certifier 28d. Certifier 28d. Location (Street and Number or Rural Route Num City or Town, State) 28d. Certifier 28d. Certifier 28d. Location (Street and Number or Rural Route Num City or Town, State) 28d. Certifier 28d. Certifier 28d. Certifier 28d. Location (Street and Number or Rural Route Num City or Town, State) 28d. Certifier 28d. Certifie	resulting in death) Last	Due to (or as a consequent of the second of	pence of):	lez ulca	remopa	190	20 yous
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examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Descri					autopsy performed	prior to co	ompletion of cause of
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4 Homicide determined determined determined 286. Place of injury - At nome, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only) (Check only) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	1 Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	Injury		28d. Describe how in	jury occurred	
(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s	O dioido	28e. Place of injury - At no	me, farm, street, facto	ry, office	28f. Location (Street City or Town, Sta	and Number or Rui ate)	ral Route Number,
Constitution of the Linear states of the Linear states of the Linear Sta	(Check only 2 ☐ Medical Examone)	miner: On the basis of examina and manner stated.	tion and/or investigation	n, in my opinion, death oc	curred at the time, date a	and place, and due	to the cause(s)

29d. Date signed (Month, Day, Year)

March 22 2007

State Registrar

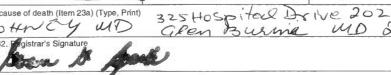
death. al or Attend after death.

within 24 hours af To the Funeral D

GURMEET 31. Date filed (Month, Day, Year) MAR 2

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29b. Signature and



SAW THE physicia

Division or Vital Records, P.O. Box 68760 within 24 hours a To the Funeral I

			1 ☐ Yes 2K No 3 ☐ Probably 4 ☐ Unknow
		· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical		26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2⊠ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Hom	e 5 Residence 6 Other (Specify)
27. Manner of Death ↑ Natural 5 Pending 2 Accident investigation		28c. Injury at Work? M 1 Yes 2 No	3d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		s, factory, office	Bf. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death or aminer: On the basis of examination and/or inves and manner stated.		nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	7 7	29c. License number	29d, Date signed (Month, Day, Year)

ive Glea Dumy Mil. 2106

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MAR 2 7 2001

31. Date filed (Month, Day, Year)

10

32 Registrar's Signature

			1 - For State Registrar	State of Mar		artment of F		Mental Hy	giene Reg. No	07	11686
Sign	Physic /Medi		1. Decedent's Name (First, Middle, Last Shirley Fat	_				2. Date of De Month	ath Day	Year O 7	3. Time of Death 13 2-8 M
1	Exami		4a. Facility Name (If not institution, give	's Hospi	tal	Cho	Location of Deat		Princ	el	beorgi's
*	Funeral Director		5. Social Security Number 5. Se 577–34–0867	x 7. Age (n yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Nov 2]	th, Year) 1, 1927	9. Birthp Cour Wast	place (State or Foreign ntry)
	Maryland a-f show	tor	10a. State 10b. County MD Calver		Oc. City, Town or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23a or 28	Funeral Director	10e. Street and Number 246 Harbor Drive			10f. Zip Code	20657		10g. Citizen of V	What Cour	ntry?
920	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show alsal Exaritrat trust be resilited at	by	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	14. Rac Blac Specify	k, White,	ean Indian, etc. nite
Maryland 21215-0036	within 72 ene. than "nai	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wor f)	rking	16b. Kind of Bu		dustry n Home
yland 2	should be filed nd Mental Hygi s markad other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) William Gorman						. Maiden Sumam	ne)	irby
	s 1 and 2 I Health a Item 27 is		19a. Informant's Name/Relationship (T) Luther Dean (husb) 20a. Method of Disposition	and)	246] 20b. Place of Dispo	ng Address <i>(Street a</i> Harbor Dr sition <i>(Name of</i>	ive Lus	by, MD	er, City or Town, 20657 20c. Location -		,
altimore,	permit. Pages Depertment of the Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		Christ E	pis. Ch. Name and Addres	Cem 20	07	Port R		Lic, MD vert, PA
8	89589		Gary J. G 23a. Part1. Enter the disease, or compl	off		125 South	ern Mary	land Blv	d Owin		
	Physician /Medical Examiner	ner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause Obsease or injury	Due to (or as a c	onsequence of):	enuton	<u> </u>				Interval Between Onset and Death
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rds, P	sign d be	þ	Part II. Other significant conditions cor	ntnbuting to death but n	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did to		ribute to th	ne cause of death? ably 4 Unknown
al Records,		Completed						24a. Was autop perfo 1 \(\text{Yes} \)	rmed?	Vere autoporior to con leath?	psy findings available apletion of cause of 2 No
Vital	Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner?	lospital:	2 ER/Outpatien	t 3D DOA Othe	ar.	th Check only o			
ion of	Jing PI	⊢ ∦	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day You	28b. Time of Injury	28c. Injury Work	at	28d. Describe	dence 6 Other now injury occurre the STac	ed, F	<u> </u>
Division	To the Hospital or Attending Phwithin 24 hours atter death. To the Funeral Director: Atter th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (Specify) hom	2		Lug E	y rugy	7 HA	4600 Drive
	To the Hospital or within 24 hours after To the Funeral Dir.	Medical	one)	sician: To the best of ner: On the basis of ex and manner stated	amination and/or in	vestigation, in my op	oinion, death occu	rred at the time,	date and place, a	and due to	the cause(s)
	5 1 1 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	<	29b. Signature and title of certifier Aurudu	Shorter	Do	29c. License			March		
	20		30. Name and address of person who salvador Sylvan	Je- 3001	Hospita	Print) L Drin	e Che	verl,	May	Can	el
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	f a	,	0	9		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Del Toro Month Jane Patricia **Physician** March 26, 2007 5:49 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 M 2 XF 353-34-0980 22, China Director 1926 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Florida Broward Pompano Beach 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 4903 NW 2nd Avenue 33064 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No SpecifyWhite 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last)
Michael Conlon 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Veronica Beggs ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Armando Del Toro/Son 7405 Pyle Road, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot Metropolitan Crematory March 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 29 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licenses Francis J. Coll 500 University lins Funeral Home Inc. Blvd, W, Silver spring, MD 2090; 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA resulting in death) /Medical Due to (or as a consequence of): Examiner CARMOMYSPATHY CONGES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 X No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 No 2 No 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Natural Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier # Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 27660 M.D 0 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre M.D. 11119 Rockville Pike, #G100, Rockville, MD 20852 Coswami, Alpana 32. egistrar's Signature 31. Date filed (Month, Day, Year) State MAR 29 2007 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** March 25, 20°07 3:53р м Pasquale DeMarco /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 390 Wilett Court Severna Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs, last birthday) **Funeral** 112 M 2 □ F 82 Yrs. 143-16-4876 Dec. 15. 1924 Pennsylvania Director Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 ▼No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21146 390 Wilett Court within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced WW II 'natural', Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 A & P Grocery Store Produce Manager 9 other filled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be filesalth and Mental H m 27 is marked otl Be Annie Tureo Philip DeMarco traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, MD 21146 390 Wilett Court Corrine A. Macon/Friend Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Agnes Cemetery Pages 1 20c. Location - City or Town, State 20a. Method of Disposition March 30, 1 ☐ Burial 2 ☐ Cremation 3X Removal from State injury or West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie P.A. Severna Park Funeral Home Severna Park, MD 21146 Hwy. 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician -una cancer nouth /Medical Due to (or as a counquence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the Records, P.O. 9∏Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy The performed certificate 1∐ Yes 2 or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28h Time of 28d. Describe how injury occurred Injury at Work? After Certification: Division Hospital or Attending 5 Pending investigation Natural within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No (2 ☐ Accident 3 ☐ Suicide .6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIVA 900 Best-cate Road #300, Annaplis, MD Z1401 MI Werne

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 24,2007 Physician Alan T. Drechsler 2:55 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritage Harbour Health & Rehab Ctr. Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year)
August 8,1924 Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 82 578-26-9785 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Director Anne Arundel Riva 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2782 Cedar Drive 21140 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 数型 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Assembly Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William F. Drechsler, Sr. Agnes L. Schrider ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickie L. Rankin - Niece 2782 Cedar Dr., Riva, MD 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 3/28/2007 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd., Edgewater, · Kales MD 21037 23a. Patt En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtk, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician thed for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter I be detached for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performen? To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 ₩atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Name and addre 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

MAR 2 8 2007

			For State Registrar	State of Maryla		artment of F tificate of			giene Reg. No. 2 A A T	11690
	Physici	an	1. Decedent's Name (First, Middle, Last Dale Matthew Ell	· .				2. Date of Dea Month	Day Year	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give			4b. City. Town, o	r Location of Death	March	26 2007 4c. County of Deat	7:30 A M
j.	Examin	er	217 Gibson Road				apolis		Anne Ar	rundel
Jan 1	Funeral Director		303-20-2434	ex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 5,	9. Birt (, Year) 1927 Ne	hplace (State or Foreign untry) Boraska
	Maryland a-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		City, Town or Lo	cation	Annapoli	s		10d. Inside City Limits 1XX es 2 □ No
	th with the 23a or 28a ıst be noti	Funeral Director	10e. Street and Number 217 Gibson Road			10f. Zip Code	21401	1	10g. Citizen of What Co U • S	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy figury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1945		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 1 No	lispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
21215-0036	n 72 hc " natu l edical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	I (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Business/	Industry
212	d withii giene. er than the M	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		ts Manage	•		Service (<u>L'enter</u>
Maryland	uld be file Mental Hy, irked othe	To Be C	17. Father's Name (First, Middle, Last) Jesse J. Ellis					e (First, Middle, ce Arno	Maiden Surname)	
, Mar)	and 2 sho ealth and I n 27 Is ma ier trauma		19a. Informant's Name/Relationship (Mary Elizabeth D.	. Ellis/wife	217	Gibson F	Road Anna	polis,	7	21401
nore	ages 1 int of He t: If Iter / or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Inemoval hom State		sition (Name of matory or other pla s Cemete		Date / 2007	20c. Location - City or Annapolis,	
Baltimore,	permit. P. Departme Important any Injury once.		4 □ Donation 5 □ Other (Specification 2). Signature of Funeral Service Licer		22	2. Name and Addre	ess of Facility Joh	ın M. Ta	ylor Funera , Annapolis	al Home
58760,	Cate be executed hysician and physician and the burial-transit the burial-transit	al Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	blications that caused the de one cause on each line. a. Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.)	Obstraction of the property of	er the mode of dying water of Carada	and such as cardiac chung Dmyo	path	rest, ease	Approximate Interval Between Onset and Death 75 yrs 2 1/2 yrs 2 1/2 yrs
P.O. Box 687	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	tal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date of del Month	ivery Day Year
ds, P.	uires that t signed by id be detac	þ	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlying cause giv	ven in Part I.		obacco use contribute to	
I Records,	The law req ate has been page 2 shou	Completed						24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat	1.0		
Division or Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has acompletely filled in by the funeral director, page 2	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	□ ER/Outpatier 28b. Time o Injury	f 28c. Inju	4 □ Nursing Ho	——/ \	dence 6 □Other (Spe	city)
Divi	al or Att s after de al Direct ed in by t	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe		reet, factory, office		28f. Location (S City or Tow	Street and Number or Re vn, State)	ural Route Number,
	he Hospi in 24 hour he Funer: pletely fille	Medical (nysician: To the best of my k niner: On the basis of exami and manner stated.		vestigation, in my	opinion, death occur			
) ,	X Total	Ž	29b. Signature and title of certifier	inson r	10	29c. Licens	50016	//	29d. Date signed (Mont	
	<i>A</i> .		30. Name and address of person who BARBARA 31. Date filed (Month, Day, Year)	completed cause of death (It + U.T.C.H.I.N.S. 32. Registrar's Sig	ON	888 B	estgate	Rd H	Anapolis	MD
	Sta Regist		MAR 2 7 200				1			
DH	MH 17 Rev 1/2	001		V						

07-02606	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Howard H. Freeland, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Day April 5, 2007 Freeland, Jr. 1244 hrs Howard Η. **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Calvert Memorial Hospital 9. Birthplace (State or 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Foreign Wash., Hours Director 07/03/1949 212-56-4547 1 X M 2 F 57 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 No 28a-f show Chesapeake Beach MD Calvert or items 23a or 28a-f sho must be notified at once. with the Maryland 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 20732 USA 3851 Breezy Point Road Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married Yes Specify: Black Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates: "natural". ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed within 72 land Mental Hygiene. Printing Co. other than the Medical Baltimore, MD 21215-0036 Printer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filement of Health and Mental Hy tant: If irem 27 is marked of or other traumatic event, the Howard Freeland, Sr. Weltha Purvev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20732 Brenda Freeland/wife 3851 Breezy Pt. Rd. Chesapeake Bch.,MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 X Removal from State Crematory 4/14/2007 Alexandria, VA Metro. Donation 5 Other Specify: 9 22 Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 21. Signature of Funeral Service Licen rdes Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line hypertensive cardiamyopathy complicating dialysis procedure for Approximate Interval **Physician Between Onset and** /Medical end-stage renal disease Immediate Cause (Final disease) Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED sician *#5336,27,perME, g868, 6/13/07 TI Hospital or Attending Physician: The law requires that the death certificate be Box 68760. tending phys 23c. If ves, outcome of pregnancy IE EEMALE 23b. Was decedent pregnant in the Year Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ું Unknown 23e. Did tobacco use contribute to the cause of death? PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? page 2 1 🗸 Yes ✓ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Other Nursing Home 5 Residence 6 Other: DOA Inpatient 2 V ER/Outpatient 3 ဥ 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 X Natural Division 1 Yes 2 No Pending death. Director: 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number April 6, 2007 O.C.M.E

State Registrar

Theodore M. King, Jr., MD.

2007

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

State Registrar DHMH 17 Rev 1/2001

hurchton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5851 - Deale Churcheo

Deale

31. Date filed (Month, Day, Year) MAR 2 9 2007

D. 50653

Road

GYAN.C.

3-29-2007

SURANA

07-02346 Freida Gregg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 11693 1- For State Certificate of Death Reg. No Registrar_ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 27, 2007 0125 hrs Medical Examiner GREGG FREIDA С. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 5. Social Security Number If Under 1 Year 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 24Hrs. **Funeral** Foreign Vinginia Country) Days Months Min Hours Director 214 36 1811 69 April 4,1937 1 M 2 X F Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show MD. Montgomery Rockville Yes 2 XNo ies I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4800 Bready Road 20853 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11, Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 X Married 2 X No White Yes If Yes, Give Yaar 1 Yes 2 X No specify: 3 Widowed 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Remodeling 21215-0036 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Walter E. Della Be Nee1 19a. Informant's Name/Relationship (Type, Print) ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward C. Gregg, Husband 4800 Bready Road, Rockville, Md. 20853 item r trau 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: I Union Cemetery 3/30/07 Burtonsville, Md. Donation 5 Other Specify: 22. Narmelan Acotessial Face ARBER FUNERAL HOME aturu / Funeral Service Licensee P.O. BOX 5038, LAYTONSVILLE, 20882 29a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Possible exsanguination due to renal biopsy Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical LINPENDED AMENDED attending physician or use as the burial 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ₽ ے Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? Yes 2 V No Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 Yes After 28a. Date of Injury (Month, Day,Year) Unknown 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject underwent renal biopsy 1 Natural Unknown Yes 2 ✔ No Pending the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State)
Good Samaritan Hospital, Baltimore, MD within 24 hours at determined (Specify) Hospital Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 20 O.C.M.E. March 27, 2007 ame and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. Assistant Medical Examiner egistrar's Signatu State 2007

DHMH 17 Rev 1/2001 OCME 2006

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH **Physician** 10:00A M 23, 2007 GENIES DANIEL W. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY Silver Spring 10106 Devere Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 24, 1933 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Maryland 213-30-5332 74 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Silver Spring MD Montgomery Director with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20903 U.S.A. 10106 Devere Court death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinen ones. Y Yes 2 No
If Yes, Give
Year or Dates: 52-55 1 ☐ Never Married 2X Married 1 ☐ Yes 2 XNo Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Univ. of Maryland Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Dove Daniel Genies ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10106 Devere Court, Silver Spring, MD 20903 (Sister) Eleanor Genies 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD Gate of Heaven Cem 3/30/07 4 □ Odnation 5 □ Other (Specify)
Signature of -uneral Service I cens 22. Name and Address of Facility SNOVDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 SON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcinoma of Colon Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown <u>Arteriosclerotic Cerebrovascular Disease</u> 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension 24a. Was an autopsy performed? Coronary Artery Disease certificate 1∐ Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 █ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2K No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760,

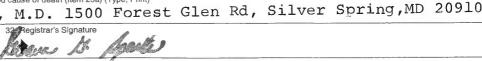
Baltimore, Maryland 21215-0036

State Registrar

Robert H. Gerard, 31. Date filed (Month, Day, Year) MAR 2 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D0055522

29d. Date signed (Month, Day, Year)

Mar. 27, 2007

			State of Maryland / [•	lealth and Me		9007 11697
			1 - State Registrar	Certificate of		Reg. N	
П	° Physicia	an	1. Decedent's Name (First, Middle, Last)				3. Time of Death
	/Medic		Paul Gilbert HESS 4a. Facility Name (If not institution, give street and number)	4b City Town o	r Location of Death	larch 31	2007 2:50 a M
	Examin	er	Julia Manor Nursing Home		erstown		Washington
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year	If Under 24 Hrs. §	B. Date of Birth (Month, Day, Yea	Birthplace (State or Foreign
	Director		214-09-5065 1XIM 2 F 95	Yrs. Months Days	Hours Min.	Oct. 7 19	
	pur 🖈		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	m or Location			10d. Inside City Limits
	Aaryle f sho	ō					1 ☐ Yes 2 M No
	the N	Director	Maryland Washington 10e. Street and Number	Hagerstown 10f. Zip Code		10g. C	Citizen of What Country?
	3s or		20009 Rosebank Way	217	40		USA
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba		ify Yes or No-	14. Race - American Indian, Black, White, etc.
9	after or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	1 Yes 27 No	Specify:	ican, etc.)	Specific
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21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28e-f show the Wolfell Examinations is the natified at	Completed	(Specify only highest grade completed)	 Decedent's Usual Occup (Give kind of work done life. DO NOT use retired 	during most of working	7	Kind of Business/Industry
77	iene.	шо	Elementary/Secondary (0-12) College (1-4or 5+) 12 0	Machinist	•		Truck Mfg.
פַ	e filec of he vent,	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maide	
<u>la</u>	uld b Ments urked	2	Maurice E. Hess		Margaret	E. Schlei	gh
Maryland	2 sho and Is mu		19a. Informant's Name/Relationship (Type, Print) 19b	. Mailing Address (Street	and Number or Rural	Route Number, City	or Town, State, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23s or 28e-1 show any injury or other treumatic svent, the Modical Examination ust be notified at once.	7 1		O. Box 373 f Disposition (Name of	Emmitsbur		and 21727-0373 Location - City or Town, State
Baltimore,	if of h	1 8	1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemete	ry, crematory or other plac	ce)		•
를	it. Pa intmer intent njury		* 4 □Donation 5 □Other (Specify) Rose I 21. Signature of Funeral Service Licensee	Hill Cemeter 22. Name and Addres			erstown, Maryland
Ba	permi Depa Impo any ir		Fad Interest		11111	nich Fune	eral Home wn, Md. 21740
			23a. Part1. Enter the disease, or complications that caused the death. Do				Approximate
H	Physician	(E) 16	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	- N	rtery	Disc	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a		1 (417	717	
n	Examiner		Sequentially list conditions, b. Database	rtensior	1		
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Вох	death certificat e attending phy of for use as th	M/ul	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy	,		23d. Date of delivery
B	0 0 2	Physician/M	1 Yes 2 No	5 Other (specify)			Month Day Year
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Ö	w requir been si should	Completed					
Rec	The law ate has page 2 s	m	-			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ā	icien: Th certificate rector, pag	e Co	25. Was case referred to medical		26. Place of Death	1 Yes 2 1	
>		To B	examiner? 1 Yes 2 Ho Hospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA Oth			6 ☐Other (Specify)
סו	g Ph ter thi		27. Manper of Death 28a. Date of Injury 28b.	Time of 28c. Injury Wor		3d. Describe how in	
ioi	Attending is death. ector: After by the fune	atic	2 Accident investigation		Yes 2 □ No		
Division of Vital Record	or Att fter de direct n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, street, factory, office	28	3f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	pitel	Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge	a dooth accurred at the tir	mo date and place as	od dua ta tha aguan	(a) and manner as stated
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	ledicai	(Check only one) 2 Medical Examiner: On the basis of examination are and manner stated.	id/or investigation, in my o	ppinion, death occurred	d at the time, date a	nd place, and due to the cause(s)
	To the within. To the comple	Me	29b. Signature and title of certifier	29c. Licens	e number	29d. C	Date signed (Month, Day, Year)
)			Jan muney	170	60396		03/31/07
			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	6 opa	ct	
9	4-2		FARID MURSHED		Hogers	FOUN	MD 21740
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 3 2007 32. Begistrar's Signature	Spell	0		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 10:28™ **Physician** Ampela Harkness March 29 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Asbury- Solomons Health Care Genter Solomons Calvert Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 26 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** 1 M 2 → F 95 Maryland 1912 216-46-7419 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Maryland Calvert St. Leonard 1 ☐ Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5410 Beach Drive 20685 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white by 3 Novidowed 4 Divorced Year or Dates: "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker other 18. Mother's Name (First, Middle, Maiden Surname)
Maude Thompson 17. Father's Name (First, Middle, Last) Be Department of Health and Mental H Important: If Item 27 Is marked ott any injury or other traumatic ever once. Jonas Feiser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5410 Beach Dr. St. Leonard MD 20685 Kathryn H. Barnett -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place April 3 2007 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Church Cemetery Port Republic MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home BKC 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Se grentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: lf yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 22 No 1□ Yes certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After Injury 12 Natural 5 □Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 鴙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 30 2007

State Registrar

Sylvia Batong, MD 11845 H.G. Trueman Rd. 31. Date filed (Month, Day, Year) MAR 3 0 2007

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lusby, MD 20657

			1 = For Amend #2&19a P	State of Maryla er Phy all (-		-	11699	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	runca	le oi Deal	(f)	2 Data of Da	Reg. No.	001	3. Time of Death	
	Physici	an	James F. H						2. Date of De Month	am 29 Day	Year		
	/Media		4a. Facility Name (If not institution, give			4b Cibe	, Town, or Location		March	28	2007 County of Dea	0020 A	
	Examir	ier						on or Death			•		
	Euparal		41 Deep Channel D 5. Social Security Number 6. Sec		last birthday)		erlin Filyear If Und	der 24 Hrs.	8. Date of Bir	th	Norcest		
	Funeral Director			M 2□F 77	Yrs.	Months	Days Hour	s Min.	8. Date of Bir (Month, Da July 9	y, Year)	9 Pen	thplace (State or Foreign buntry) nsylvania	
	D		Usual Residence of Decedent						oury 5	, , , , ,	, , , , ,		
	how		10a. State 10b. County		ity, Town or Lo							10d. Inside City Limits	
	6 Ma	cto	MD Worceste	r	Berl	ın						1 ☐ Yes 2 🕅 No	
:	permit. Pages 1 and 2 should be lied within 72 hours after deeth with the Maryland Depertment of Heath and Mental Hygiene. Depertment: If tien 27 is marked other then "natural", or items 23a or 28e-f show eny injury or other traumatic event, Ite Madical Examinat most be nutified at apprex.	Funeral Director	41 Deep Channel	Dr.		10f. Zi	21811			10g. Citi.	zen of What Co S	ountry?	
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Maryland 21215-0036	ire!'.	d by	3 Widowed 4 Divorced	Year or Dates:	53	103	ZLANO Spec	y.			Specify: Wh	100	
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pur !	d of H	Be	17. Father's Name (First, Middle, Last)							, Maiden	en Sumame)		
3	Mer Mer	၉	George Hopton					nna Le		- 12			
a Z	nanc I e n		Jacqueltine -/Relationship (Ty	_			s (Street and Nur					Zip Code)	
o o	Health		Jackie Hopton (wi	athod of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town									
Baltimore,	or of the		1 Burial 2 Cremation 3 R		cemetery, crei		20c. Location - City or Town, State						
Ë	tant:		4 ☐ Donation 5 ☐ Other (Specify)	∣ He	phziba	h Ba	07	Coa	tesvill	e, PA			
39	Depermit Deper Impor eny In		21. Signature of Funeral Service License				nd Address of Fa					Home	
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E	Examiner						,						
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Division of Vital Records, P.O. Box 68	Attenuing Friysician: Trideath actor: After this certificate has been signed by the ettending physicien and actor: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3[Ectopic p				2	3d. Date of de Month	livery Day Year	
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Sic	death stor:	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	20 Place of lainer At h	ama farm at				of Location (Ctro at an	d Morentana on D	and Double Million	
N N	s after of all Directed in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, rarm, str	eet, factor	y, office	4	City or Tov	vn, State)	d Number of Hi	ural Route Number,	
	To the Population Attending Prysician: The law within 24 burns after death. Wher this certificate has To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only onle) Certifying Physical Carming Control on the cont	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	h occurred vestigation	at the time, date n, in my opinion, o	and place, a death occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)	
	Withir To the comp	ž	29b. Signature and title of certifier			29	c. License numb	er		29d. Date	e signed (Mont	h, Day, Year)	
) .	-		LIWSA 66th	omo			D3061	19		3/2	19/200	7	
			30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type.	Print)				, ,	. ,	•	
E.1	15			VMD 10445	old Oc	ean C	ty Blud S	Suite 1	Berl	N W	nd 218	11	
10	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1 com				- '		- 1	
	Registr	- Marie Mari											

DHMH 17 Rev 1/2001

07-02283 Kermit Hurley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Rea. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Month Day March 24, 2007 Kermit Hurley 2206 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours oreign 219-56-0862 1 X M 2 F 53 L1/19/1953 Country) MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Calvert Chesapeake Beach 1 Yes 2 x No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If (tiem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Media Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6580 Old Bayside Road 20732 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 2 X No Yes Black 3 Widowed Yes, Give Year Divorced 1 Yes 2 No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 11 Cement Finisher Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles Hurley, Jr. Inez Brown 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Hurley/sister 834 Yardley Dr. Prince Fred., MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State or other crematory or other place) 1 Burial 2 Cremation 3 Removal from State St. Edmonds UMCCem 103/30/07 4 Donation 5 Other Specify: Chesapeake Bch., MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell 1451 Dares Beach Rd. Funeral Home Pladup 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical en Onset and a. Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). ransit Physician/Medical attending physician or use as the burial UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown the Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of performed? certificate Yes 2 V No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26.Place of Death (Check only one) examiner? Other₄ this DOA Nursing Home 5 ဥ 1 V Yes Residence 6 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural neral Director: hours after death. Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) within 24 hours a (Specify) Homicide 29a. Certifier 1 (Check only completely Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 27, 2007 how 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Month, Day, Year, MAR 2 9 200) 32. Registrar's Signature State Registrar

			For State	State of	of Marylan					ental Hygi	ene	7 () "7	1170
			Registrar 1. Decedent's Name (First, Middle,	(act)		Cer	tificate (or Death		Re 2. Date of Death	g. No.	111	3. Time of Death
	Physicia /Medic		Margaret H. He							Month March	Dav	2007	12:36 PM
}	Examin	100	4a. Facility Name (If not institution, Anne Arundel Me				4b. City, Tow	n, or Location Anna	of Death		4c. County Anne	of Death e Aru	ındel
	Funeral		5. Social Security Number 075–26–8546	3. Sex 1 ☐ M 2 X F	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Y Months Da	ear If Unde	Min.	B. Date of Birth (Month, Day,		Coun	lace (State or Foreign stry) V York
	Director		Usual Residence of Decedent		02				l lu	July 2,	1924	Mew	V YOLK
	rylanc how		10a. State 10b. County	1 - 1	10c. Cit	ty, Town or Lo	cation	Anna	nolia			1	0d. Inside City Limits
	Ba-f s	Director	Maryland Anne A	runaeı			100 7 0		polis	14/)- O''('	N/h = 4 O a s = n	1 ☐ Yes ŽŒNo
	h with th	al Dir	10e. Street and Number 523 Epping Fore	st Road			10f. Zip Co	21401			og. Citizen of V U . :	S.A.	ntry?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	Armed F	2∕√X No ive	1	Was Decedent f Yes, specify 1 ☐ Yes 💥 🛣			ify Yes or No- lican, etc.)	Blac	e - Americ k, White, Whi	etc.
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7	filed v Hygie other t		17. Father's Name (First, Middle, Li	a <i>st)</i>		1 Adit	LIIIDCIG			(First, Middle, N			
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20	d 2 sho th and 7 is m traum		19a. Informant's Name/Relationshi Suzanne Patters	_{p (Type. Print)} on/siste	r in la					Route Number,	City or Town, Ogden,		84403
ה ה	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name o	f	Da		20c. Location -		
2	Pages nent of Hant, if ite		1 ☐ Burial 2 ☐ Cemation 3 4 ☐ Donation 5 ☐ Other (Spe		i State	-	e Crema		3/21/2	2007 E	Baltimo:	re, M	Maryland
Dallino	permit. Departn Importa any Inju		21. Signature of Funeral Service Li	censee	Min					M. Tay			Home MD 21401
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	Physician		Immediate Cause (Final disease or condition	(In one dause on	Polonic	, ob	struct	im					Onset and Death 24 days
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O. DOX O	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 15 No 9 □ Unknown	1 ☐Live	utcome pf pregn birth 2 □ Feta gnant at time of c nown	al death 3	∃Ectopic pregr ∃Other <i>(specii</i>					te of delive	ery Day Year
7.	requires that the een signed by the rould be detache	by Ph	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying caus	e given in Parl	t I.	23e. Did tob	acco use cont	ribute to ti	he cause of death?
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	or Atterder Director in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be ned 28e. Place build	ce of injury - At h ding, etc. (Speci	ome, farm, str	eet, factory, of	fice	28	8f. Location (St. City or Town	reet and Numb n, State)	er or Rura	al Route Number,
_	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	ledical Ce	(Check only 2 ☐ Medical E	Physician: To the	basis of examina	owledge, deat ation and/or in	h occurred at t	he time, date a	and place, a eath occurre	and due to the ca	ause(s) and ma	anner as s	stated. o the cause(s)
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_	0		30. Name and address of person w	ho completed cau	use of death (Iter	m 23a) (Type, Medrca	101	way	Anna	polis	MA	2	1401
Ì	Sta Registr		31. Date filed (Month, Day, Year) MAR 2		Registrar's Sign	ature	hands	/		1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Donald Baker Justice 1:35 A March 29 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solarans Nursing Center Solarans Calvert. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1∏M 2□F 73 Feb 22 1934 Washington DC Director 214-30-1086 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f shov notified at Calvert Lusby Maryland 1 TYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rai", or items 23a or Examiner must be United States 1168 White Sands Drive 20657 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 52–56 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natu trau⊓atic event, <u>the Medical</u> 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) IRS/Computer computer specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Simon 2 Norris Justice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacculine Justice- wife 1168 White Sands Dr. LUSby MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: if it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middleham Chapel April 2 2007 Lusby Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Obstructive Chronc /Medicai Due to (or as a consequence of): Examiner Sequentially list conditions, it any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a nonsequence off Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No for Month signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? page certificate 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by t 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

State 31. Date filed (Month, Day, Year)

Registrar MAR 3 0 2007

David Tardio MD 110 Hospital Dr. Prince Fredercik MD 20678

10 (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician James Calvin KIRK ADI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Dave | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1X M 2□ F 78 July 27, Director Maryland <u>218-24-7947</u> Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits r 28a-f show notified at 10b. County 10c. City, Town or Location 1 X Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 21740 USA 351 Central Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crane Mfg. 12 0 Stock Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Kirk <u>Molly Mason</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is n any Injury or other traun 10811 Oak Valley Drive, Hagerstown, Md. 21740 James R. Kirk - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park 4/5/07 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute 1000 m Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner death certificate be executed burial-transi Shac Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Onknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 1□ Yes 2 **N**No al or Attending Physician: 's after death.'

I Director: After this certificated in by the funeral director, p Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Hipatient 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manney of Death 28c. Injury at Work? Certification: 1 Devatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 2th, 2007 D62588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WH-10

31. Date filed (Month, Day, Year)

APR 0 3 2007

SUDITIF

MBAOUA. 251 E. Antherson St Hagerstown, My (Year) 32. Registrar's Signature

Signature . Speck

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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E. A. Liet.

egistrar's Signature

			State of Maryland	•	rtment of H			20	0.7	and the same of th	705
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of L	Jean	2. Date of Dea	Reg. No. 💪 🔱	U /	3. Time of	Death .
	Physicia /Medic		Rufina Foronda Ledezma				Month March 2	Day	Year	7:40	р ^М
•	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	of Death		
			Montgomery General Hospital			lney			lontgo		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 1	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 9	y, Year)	Count	ace <i>(State o</i> ry) ivia	r Foreign
			Usual Residence of Decedent				oury o	,			
	how at		10a. State 10b. County 10c. City,	Town or Lo	cation				10	d. Inside Ci	
	e Ma Ba-f s	cto	Maryland Montgomery	Silv	er Spring	<u></u>				1 🗌 Yes	2 <u>X</u> NO
	or 2	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of W		ry?	
	s 23a	ral	13925 Valleyfield Drive 11. Marital Status 12. Was Decedent Ever in U.S	10.1		906	ooifu Voo or No	Boli	.Vla e - America	n Indian	
_	ter de item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	-	Vas Decedent of Hi f Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black	k, White, e		
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Hem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ğ	3 ¥ Widowed 4 □ Divorced	1	Yes 2□ No	Specify: B	olivian	Specify:	Whit	te	
2	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupa	during most of work	ing I	16b. Kind of Bu	siness/Indi	ustry	
V	ithin ne. han "	ם	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired) -					
V	lled w lygie ther th		3 17. Father's Name (First, Middle, Last)	Hom	emaker	18. Mother's Name	e (First, Middle,	Own H Maiden Surname			
ב ס	the factor of th	Be c	Modesto Ledezma		Mak	ia Foron			-,		
2	should bd Me mark matic	ည	19a, Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a			er, City or Town,	State, Zip	Code)	
Š	nd 2 alth al		Emma M. Davila/ Daughter		1 704 9 01d	Baltimo	re Road	, 01ney,	Mary	/land	20832
,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 20b. Pla	ace of Dispo	sition (Name of natory or other plac	ee)	Date	20c. Location -	City or Tov	wn, State	
	Page ment ant: If ury or		↑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate	of H	eaven Cem	netery 2	rch 31 007	Silver S	pring	g, Mar	yland
ğ	permit. Departi Import any Inj once.		21. Signature of Funeral Service Licensee		Francis J						
	90 E # 9		James & Cooling		500 Unive						
	•	0 4	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximat Interval Bet Onset and I	ween Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	119					_	· · · · ·	
	Examiner		Due to (or as a conseque	ence of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Unioritying Cause (Disease or injury that initiated events	ence of):							
	outed Id ansit	Examiner	Cause (Disease or injury that initiated events								
Š	e exe ian ar urial-t		resulting in death) Last Due to (or as a consequence of the consequence)	ence of):							
0/00,	death certificate be executed e attending physician and of for use as the burial-transit	dical	d								
0 X 0	ding p	/Me	IF FEMALE: 23c. If yes, outcome pf pregnar	icv				22d Date	a of daliva		
0	atten for us	cian	in the past 12 months?	death 3□	Ectopic pregnancy Other (specify)	<u>'</u>		Z3d. Dati	e of deliver	-	Year
	the d y the	Physician/Me	1 ☐ Yes 2 ☐ 4 ☐ Pregnant at time of de 9 ☐ Unknown								
7. T	w requires that the death certific been signed by the attending p should be detached for use as	by Pt	Part II. Other significant conditions contributing to death but not resul	ting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use contr	ibute to the	e cause of c	leath?
cords	en sig	ed b					10	Yes 2000	3 Proba	ably 4 ∐l	Jnknown
Š	The law nate has be	plet					24a. Was auto	osy p	Nere autop	osy findings apletion of c	available ause of
=	The cate h	Completed					perfo 1□ Yes	ormored? d	death? I∐Yes	2 🗌 No	
<u> </u>	iclan; sertific	Be	25. Was case referred to medical examiner?		. all Doa Othe	26. Place of Deat					
5	Phys r this ral dir	10	The inpatient 2 E	:R/Outpatien 28b. Time of	I SLI DOA	4 LI Nursing Ho		dence 6 Other		')	
	ading th. : Afte fune	tion	A Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Worl	k? Yes 2 □ No		,,			
<u>S</u>	Atter r dear ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At hor building, etc. (Specify,	ne, farm, str	eet, factory, office		28f. Location (Street and Number	er or Rural	Route Num	nber,
5	tal or s afte al Dir ed in	Certification:	Building, etc. [Specify]				City of Tol	wii, State)			9
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier (Check only one) Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	rledge, deati on and/or in	n occurred at the tir vestigation, in my o	me, date and place, ppinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s	s)
	o the ithin 2 o the omple	Medical	29b. Signature and title of conflict.		29c. License	e number		29d. Date signed	d (Month, I	Day, Year)	
1	ー メト ö		→ III/ KX MD		Dos	X6319L	,	Man	cah 20	3, 200	17
,			30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	5,18		11>	011 20	200	
			Hattwew M(Avovou 18 01 31. Date filed (Month, Day, Year) 339Registrar's Signat	PMN	ce Phili	p Drive	Olu	by MI	> 0	1085	200
ı	Sta Registr		31. Date filed (Month, Day, Year) ARR 2 9 2007	and And	all 8	ı		1			
			Part Part Control Part	43.20	NAME OF THE OWNER OWNER OF THE OWNER						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day 1100 **Physician** DONVED MULEN 15V2 200 /Medical 4a. Facility Name (If not institution, give street and number)
12225 Funkhouser Road 4b. City, Town, or Location of Death 4c. County of Death Examiner Clear Spring, Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1. M 2□ F COMPLY) 215-14-1089 85 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "natural", or Items 23a or 28e-f show other treumatic event, tha Medical Evanarian and be mytified at Clear Spring MD Washington 1 ☐ Yes 2X No Director 10e. Street and Number 12225 Funkhouser Road 10f. Zip Code 21722 10g. Citizen of What Country? death with Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 1944

If Yes, Give 1046 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If tiem 27 le marked other than "natural; or Item any injury or other treumatic event, the Medical Eventend 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 1946 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) aircraft mfq. Elementary/Secondary (0-12) College (1-4or 5+) bonding applicator 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nellie Jane Cunningham Edward Dewey Mullen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace V.Mullen wife 12225 Funkhouser Rd.Clear Spring, MD 20b. Place of Disposition (Name of April 3, D2007 Blairsvalley Cemetery 20a. Method of Disposition 20c. Location - City or Town, State \$☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Clear Spring, Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a shock, or he if failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCHEMIC CARDIOMYOPATHY Physician disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MY SLOPROLIFERTIVE DISCROEL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan rmed No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 Z No in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

Certification: To

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

Natural

2 Accident

3 🗌 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2/200

Hancock MD 21750

Location (Street and Number or Rural Route Number City or Town, State)

d cause of death (Item 23a) (Type, Print)

5H-10+1 State Registrar

After

death.

after death

within 24 hours a To the Funerel C

To the

Medical

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician March 2ŎÖ7 22:35 M Pompeo Paul Manna /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hagerstown 1175 Professional Court If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 10 1915 9. Birthplace (State or Foreign **Funeral** Days 1X M 2□ F Hours Yrs. Director 168-03-0592 91 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow ?7 is marked other than "natural", or items 23a or 28e-f eho: treumatic event, it e Medical Exacts or must be positived at Maryland X Yes 2 □ No Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1175 Professional Court 21742 U.S.A. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces? 1 (19 Yes 2 □ No 9-1 If Yes, Give Year or Dates: 11-4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-42 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9-16-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White 11-4-45 Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Truck Mfg. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil iment of Health and Mental H tant: if Item 27 Is marked otl Be Carmella Laocino Manna Anastasio Francisco Manna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18718 Rolling Road Hagerstown Maryland 21742 19a. Informant's Name/Relationship (Type, Print) C. Joyce Ripple (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or once. Smithsburg Crematory 4-2-07 Smithsburg Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Director: After this certificate has been sign in by the funeral director, page 2 should be 2 100 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2D No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? Bread map us 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ◯ X(o ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. 1 □ Yes 2 □ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 | Homicide filled in 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)) h b 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H9+1 Hagenstown, MD 21740.

State Registrar

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31. Date filed (Month

32. Pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Physician 5:25 Рм March 21, Carmen Mercado /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 3204 Norshire Terrace Bowie if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday **Funeral** Days Puerto Rico Hours Min 1 ☐ M 2 🗓 F 1919 87 Director 052-24-3564 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at TY□Yes 2 □ No Director Maryland Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code d other than "natural", or items 23a or event, the Medical Examiner must be a USA 20716 3204 Norshire Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after. Heath and Mental Hygiene. em 27 is marked other than "natural", or iten ther traumatic event, the Medical Examiner 1 □ Never Married 2 □ Married ^{Specify:}White 1X Yes 2 No Specify: Puerto Rican ş 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Eiementary/Secondary (0-12) Food Service Factory Worker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herminia Lisboa Francisco Rosa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3204 Norshire Terrace Bowie, MD 20715 Carlita Rivera/ Daughter permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tragonce. 20b. Place of Disposition (Name of cemetery, crematory or otherp Sacred Heart Jesus Cemetery 20c. Location - City or Town, State 20a, Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 03/24/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** near /Medical Due to (or as a consequence of): **Examiner** Hypen tens vo
Due to (ocas a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 10 No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 ☐ Probabiy 4 ☐ Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 200 No Hospital: Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/23/07 00060120 AM MOW MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 mitchell ville Rol # B-216 Bowie on D 20716 Hagothmn, MD A. wall 31. Date filed (Month 32. Revistrar's Signature State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 10a per fd aaco hith dept 3/27/07 dlw State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 24, 2007 3:30 \mathbf{A}^{M} Stella Rita Mahoney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Spa Creek Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🗆 M May 31, 1918 Director 88 Pennsylvania 113**-**03-3270 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 19 Parvland 1 X Yes 2 ☐ No Maryland Director Anne Arundel Annapolis with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 20 Severn Ave. 21403 United States death \ Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. Be John Yurak Florence Petak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Mahoney / Son 15 Severn Ave. Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Baltimore Crematory 3/26/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Chensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrythmia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 TANo 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure to thrive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has by page 2 s certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4XXVursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes XX No ٩ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation XXNatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours 1 💢 Cyrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗀 Jediy J Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 24 and manner stated. the 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) D57028 3-26-2007

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) MAR 2 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



07-02500 James O' Donnell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day April 1, 2007 2100 hrs Medical Examiner 0'Donnell James F. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1801 Jasmine Terrace, Apartment # 101 Hyattsville Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth/MM/DD/YYYY) oreign Washington Months Hours Director 265-64-9895 65 02/16/1942 Country) 1XXM DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. 1 Yes 2 X No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
anti: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notfied at once. Maryland Prince George's Adelphi 10f. Zip Code 10g. Citizen of What Country? 1801 Jasmine Terrace #101 20783 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 X Never Married 2 Yes 2 X No 3 Widowed Divorced If Yes. Give Year Yes 2 No specify Specify: White ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Operator University of MD 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Unknown 0'Donnell Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Debra Emery / Friend 1212 Newport Mill Road, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 4/11/2007 Brentwood, Maryland Donation 5 Other Specify 22. Name and Address of Facility Simple Tribute Signature of Fulleral Service Licenses 040 Rockville Pike, Rockville, Maryland 20852 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and lure. List only one cause on each line /Medical Death a Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical physician the burial -X UNPENDED 4#238,27, perME, g867, 5/10/07 TI certificate be Box 68760 IE EEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ş 1 Yes 2 No 3 Probably 4 V Unknown ď The law requires Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? page ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) of Vital Be examiner? Other₄ Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 V Other: Scene DOA ER/Outpatient 3 1 🗸 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural Division 1 Yes 2 No 5 Pending 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be (Specify) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 2, 2007 O.C.M.E. Thy 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. Assistant Medical Examiner 32 Registrar's Signature DayYear State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Evelyn V. Plater 4:15 A /Medical Mar 27, 2007 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Days Hours Director 214-68-3043 78 Maryland Mar 7, 1929 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County t be notified at 1 ☐ Yes 2 Y No **Funeral Director** MD Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. must b 7442 Old Bayside Road 20732 U.S.A "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black þ 3 X Widowed 4 ☐ Divorced Completed Item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Gross Johnny Smith ۵ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Tear Plater /Daughter 1190 West Northern Parkway #104A Baltimore, MD 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. Burial 2 □Cremation 3 □Removal from State 4 Donation 5 Other (Specify) St. Edmonds UMC Cemetery 04/03/07 Chesapeake Beach, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dladys a. Sewell Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician disease 5+99e Lna /Medical Due to (or as a consequence of) Examiner 1abetes Sequentially list conditions. riany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed bunal-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached fo 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hecent 2 No 3 Probably 4 🖪 Únknown Be Completed Percipheral Vas culcer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s vosculces clisease Atherosclenotic 1□ 2 HNo Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 31. Date filed (Month, Day, Year) MAR 2 9 2007

29b. Signature and title of certifier



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fo the

29c. License number

50653

29d. Date signed (Month, Day, Year)

SURANA

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** March 26, 2007 4:00 p M Kathryn Regina Pessagno /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Anne Arundel Annapolis Lighthouse on the Bay Assisted Living If Under 1 Year Months Days 8. Date of Birth (Month, Day, If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) Social Security Number **Funeral** Year 1 □ M 2 🔀 F 10, 212-01-5544 Maryland Feb. 1918 Director 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County a or 28a-f show t be notified at 28a-f show 1 ☐ Yes 2 ☑ No Annapolis Director MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21409 USA items 23a 1141 Skyway Drive r than "natural", or items 23a the Medical Examiner must I by Funeral within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 N Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Catholic Rectory Secretary 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary E. Thim Henry M. Bergman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Regina A. Jones/Daughter Annapolis, MD 21409 456 Man O War Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 28, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cerebroussular accident **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) N/4 9 Unknown 23e. Did tobacco use contribute to the cause of death? certificate has been signed | rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes No 24a. Was an performed? Yes 28 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

within 24 hours atter death.

To the Funeral Director:
completely filled in by the the

State Registrar

(Check only

29b. Signature and title of certifier homes M. Walsh MD 29c. License number

29d. Date signed (Month, Day, Year) 3-27-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 277 PENIN SULA FARM ROAD ARNOLL ARNOLD MD 21012

Thomas M. Walsh, MD

32. Registrar's Signature 31. Date filed (Month, Day, Year)

07-02513 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Albert Richardson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day April 2, 2007 Medical Examine Robert Albert Richardson 0947 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 1995 West Mount Harmony Road Calvert Owings 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral 220-98-1077 Months Days Hours Director 1X M 32 Nov 4 1974 CouMaryland 2 F Usual Residence of Deceden AU A 10b. Count 10c. City, Town or Location 10d Inside City Limits 28a-f show Maryland 1 Yes 2 No Calvert yes I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "morn..." Owings Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 23a or 28a-1995 West Mt. Harmony Road 20736 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Black must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married Yes 2 X No 3 Widowed Divorced If Yes, Give Year Yes 2X No specify: Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 residential construction 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) William E. Richardson, Sr. Carol M. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol M. Whetzel - mother P.O. Box 284 Piney Point MD 20674 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 🗙 Cremation 3 🗌 Removal from State Metropolitan Funeral Alexandria Virginia Donation 5 Other Specify 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home Der Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 20676 Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Carbon monoxide intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical /sician a X UNPENDED AMENDED PII, 27, 28a-f, perME, g86, 4/23/07 TT Box 68760. IF FEMALE 23d. Date of delivery phy the 3b. Was decedent pregnant in the Day use as t Fetal death Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? P.O. 2 1 Yes 2 No 3 Probably 4 V Unknown Cocaine use Completed Records, this certificate has been if director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. uneral director, 25. Was case referred to medical Division of Vital Hospital: 1 examiner? Other₄ Nursing Home 5 Residence 6 Other: Scene Inpatient DOA 2 ER/Outpatient 3 1 🗸 Yes 28b. Time of Injury After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work 8d Describe how injury occurred subject inhaled motor vehicle Certification: Natural 1 Yes 2 X No Pending To the Funeral Director: completely filled in by the exhaust fumes FNd 4/2/2007 unk. Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be or Town, State) 1995 W. Mount Harmony Rd. Owings, M determined (Specify) Truck Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

29b

signatur

Laron Locke MD

31. Date filed (Month, Day, Year)

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

corre

30. Name and address of person who completed cause of death (Item 23a)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 3, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** March 26, 2007 5:45 A Jeffrey Francis Richardson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/6/1943 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 17 M 2□F New York 579-56-7470 63 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10a. State 10b. County 1 Yes 2 No Directo Maryland | Anne Arundel Riva 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. I important: if tiem 27 is marked other than "natural", or items 23a or 3 any injury or other traumatic event, the Medical Examiner must be n 20nes. 104 Ridge Road 21140 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Place - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Printing year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jane Flagg Joseph Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Richardson/ Wife 104 Ridge Road, Riva, Maryland 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Edgewater, MD 3/30/07 Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Lynnsee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LANCE LW /Medical Due to (or as a consequence of) Examiner remaria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dira to (or as a consequence of) physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 ☐Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page 2 has this certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) MAR 2 8 2007



Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedente Namo (First, Middle, Last) ician 2007 Fe bours JANICE LOUISE JOHNSTON dicat 4c. County of Death 4s. Facility Name (If not institution, give street and number) 40, City. Town, or Location of Death Legiscal Medical Center 9. Birthplace (State or Foreign Country) 8. Date of Birth (Money, Day, Year) 7. Aye (In yra. last b 68 MARYLAND 249 34 4893 Daul Ragidence of Decedors AUG 08 1938 10d Inside City Limite 1 Da. City, Town or Location 100. Count 1 BY 2 2 No Director CHINCOTERGUE VIRGINIA ACCOMACK 10g. Citizen of What Country? 10f. Zio Code 10e. Sweet and Number USA 23336 7229 RUNTING ROAD 14. Race . American Indian, 13. Was Decodent of Hispanio Origin? (Specify Yas of No-il Yee, specify Cuben, Maxican, Puerte Rican, etc.) 12. Was Deceden Ever in U.S. Amed Forces? 1 Server 2 No. Il Yes, Give Year or Dates: 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Spacity: WHTE 1 Ves ZM No Specify: ă 3 Widowed 4 Diverced 160. 10nd of Business/Industry 16a. Decedent's Visual Competton (Give kind of work done during most of working Ris. DO NOT use retroot) 18. Decedent's Education Comp College (1-4or 5-) Elementary/Secondary (0-12) TOOL COMMANY 12 70 MANAGEMENT 18, Motes's Name (First, Middle, Maiden Sumame) 17. Fabrara Name (Firm, Alleida, Last) EMMA LOUISE RUMBOLD HOWARD RAY SOHNSTON 2 180. Melling Arterese (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (7)ps. Print) CHINCOTEREUS VIRGINIA 27736 PO BOX 65 REBECCA TATEM LANDLERD 20c. Location - City or Town, State 20b. Pince of Disposition (Name of committees chamblers or other phase) 20s. Method of Disposition 1 Daniel 2 (Crementon 3 DRomovel from State)
4 Danation 5 DOther (Specify) 23 FEB 2007 CHINCOTEAGUE VIRGINIA SLAND CREMATORIUM 22. Name and Address of Facility FOX & HOLSTYN FUNCARL HONG 21. Signature of Funeral Service Licenses SOUT CHICKEN CITY ROAD All Toy CHIPCOTEACHE, VIRGINIA 23336 23s. Pant. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such se cardiac or respiratory errest, shock, or heart failure. Ust only one cause on each tine. Immediate Cause (Final disease of condition resulting in death) metastatic Carcinama Due to (or se it commequence of) Sequentially list conditions if any, leading to investigation cause. Enter Underlying Cause (Disease or injury that invitated events requiring in death) Last Due to (or as a consequence of): 80 Due to (of 66 (i Consequence of): 秀 Physic langual IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Feral death
4 Pregnant at time of death 28b. Was decedent pregnant 2 Fotopic pregnancy Month Dex In me peut 12 months? 6 Other (specify) DO Unknown # DUnknown 28e. Did tobacco use contribute to the beine of death? Pert II, Other eignifficent conditions contributing to death but not resulting in the underlying cause given in Part I. À Yes. 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 24e 2 No R4m West and Suppose personned? Somple 26. Pisco of Death (Check only one) 25. Was case referred to medical 8 Other: 4 Nursing Home 5 Residence 6 Other (Spearly) Hospital: 1 Ingettent 2 ER/Outpetient 8 DOA 1 Yes 25 No 0 28d. Describe how injury occurred 28b. Time of 28c. Injury El 27. Morrier of Death 28s. Date of Injury (Month, Day Your) Certification: 5 Pending Investigation Natural 1 Yes 2 No 2 T Appident 28. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be demined 28e. Place of Injuly . At home, farm, street, factory, office building, etc. (Specify) 3 T Buicide 4 DHemicide Physicien: To the Dest of my knowledge, death occurred at the time, date and place, and due to the occuse(a) and manner as stated. my my Physioten: To the best of my knowledge, death occurred at the time, date and pisce, and use or an interest product to the basic of exemination and/or investigation, in my opinion, death occurred at the time, date and pisce, and due to the sause(s) and menner stated. 29a, Cortfiel 8 (Chart only 280. Date signed (Month, Day, Year) 200 Lloadea number 280. Signature and post of confiden D 30873 Pennagla Regional Medical Center Saliday us 30. Name and address of parameters completed cause of doubt (hom 23a) (Type, Print) B Silvia JR My

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State

31. Date fled (Month, Day, Year)

FEB 26

2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death ារទ័ក 21:07 Pu FEBRUARY MARIE 22, 2007 SMITH dical 40. City. Town. or Location of Death de County of Douth 46. Featily Nema (If not institution, give sheet and number) BERLIN ATLANTIC GENERAL HOSPITAL WORCESTER COUNTY Window 1 Year | Hundor 24 Mrs. | L. Date of Birth Northis Days | Hours | Min. | Mannin Day, Year) 1. Bympiaca (Sum or Foreign Country) POWELLVILLE, MD 7. Age (in yes less birthday) 5. Social Security Number V□M 2屋F 69 221-22-4975 Yes **Usual Residence of Decedent** 10d, Inside City Umits 100. City, Town or Location 10s. Sinte 10b. Counn 1 Vet 2 No DELAWARE SUSSEX COUNTY SKLBYVILLE 10p. Citizan of What Country? 10s Street and Number 101 Zie Code ō UNITED STATES #3 SHADY GROVE, APT. 71 19975 Puneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-il Yes, specify Cuten, Maistan, Pulano Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 1 DYSS ZENO R Vos. Give Vegr or Dales: 1 Never Harried 2 Named 1 Yes 20 No Specify: Specify: WHITE 3 Widowed 4 Dilleroos Completed 16a. Decedent's Vaunt Copupation (Give kind of early dame during kin. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest greats completed) HOME HEALTH CARE Elementary/Banandary (0-12) College [1-4er 3+) HRALTH CARE AIDE 10TH CRADE 12. Mother's Name (First, Middle, Maldett Sumame) 17. Februire Hame (Plast, Mittalia, LAM) 2 MAUDE WILKINS ROY V. TIMMONS tBs. Informatics Name/Retellonable (Type, Print) 190. Meiling Address (Sheat and Number of Rural Route Number, City or Town, State, Zie Code) MACK K. SMITH (SON) 23003 NINE FOOT ROAD; MILLSBORD, DE 19966 Date EGs. Location - City or Town, State 20b. Place of Disposition (Name of complety, cramatory or other piece) 20s. Method of Disproption 1 W Burier 2 DOremetien CARRY'S CEMETERY FEB 28,2007 MILLSBORD, DELAWARE 4 Donation 5 Doner (Specify) WATSON FURBAL HOME MILLSBORD, DELAWARE 19966 -MO 1365 me theil paused the death. Do not enter the mode of dying, such 234. Part1. Enter the classes, or con-shoot, or heart fathers. List strily Approximate Interval Services Oncer and Door diala Caupa (Final disease or condition Due to (or es a consequence of) Sequentially list conditions. If any, tending to immediate cause. Enter Underlying Cause (Disease or Youry stat initiated events resulting in death). Last Our to (or as a consequence of): Examb Due to (or se a consequence of): Physiciansidadical IF FEMALE: 33c. N yes, curtosme of pregnancy 1 DLNe birth Z D Petal deal 4 Pregnant at time of death 23d. Date of delivery 23b. Was decreiont proposali ath. in the past 12 mont 1 Tes 2 No 9 Unknown Day 5 Other (appendy) MI Uramown 23a, Did tobacco use contribute to the cause of death? Part II. Other algorithment conditions contributing to death but not resulting in the underlying cause given in Part I. á Ves. 20No 30 Probably 4 DUNINGWA 3 240. Were autopsy lindings evaluation prior to completion of cause of death? 244. Was an perform 1 Yes 2 No 1 Yes 8 25. Was sase referred to medical 29, Place of Death (Check only one) Hospitel: Jacobert 2 ER/Duspetiers 30 DOA Other: 40 Numing Home 50 Residence 6 DOther (Specify) IDYAG 25 NO 0 28e. Date of Injury (Month, Cay Year) 26b. Time of 28d. Describe how injury accurred 27 Manner of Chall 29c Input at Certification: B C Pending No Returns 2 Acoklent 1 Q Yes 2 | No d □ Could not be determined 3 Sulaide 281, Lecation (Smeet and Mymeet or Flural Route Number, City of Town, State) 28s. Place at Injury - At home, farm, except, factory, office building, etc. (Specify) # Mamiokis Cordifing Physician: To the best of my increading, death occurred at the time, date and place, and due to the cause(s) and representation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier statud. 28a, Caritier (Check coly 200. Delg algred (Manift. Day, Year) 20c. Licensa number 250. Signature and title of certifie 13 39 riamp and address of a metany 21 Date Blad /Month Day 1510 FEB 2 B 2007 Elrar

1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** рм March 27, 2007 William George Stahovic 2:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13201 Foxhall Drive Silver Spring
If Under 24 Hrs Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**√** M 2□ F Months Days Hours Director 380-16-5437 85 Feb. 24. 1922 Michigan Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show notified at show 1 ☐ Yes 2 X No Director Silver Spring 10f. Zip Code Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? must be n 13201 Foxhall Drive 20906 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1¾ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status ral", or iteπ Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or ite ury or other traumatic event, the Medical Examines 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2亿 No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Stahovic Stephany Czerneto ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann B. Stahovic/ Wife 13201 Foxhall Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State March 29 4 Dona 5 ☐ Other (Specify) Metropolitan Crematory 2007 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901 21. Signay re of Funeral Service 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis 1 Week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Er terming Cause (Disease or injury that initiated events resulting in death) Last Multiple Decubitus Ulcers
Due to (or as a consequence of): Examine The law requires that the death certificate be executed Deconditioning the burial-tran Due to (or as a consequence of): Box 68760, attending physiciar Physician/Medical Severe Peripheral Vascular Disease use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Day Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Renal Insufficiency, Urinary Tract Infection 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has I autopsy performed? 2 3 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) 1 Yes 2 No P 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🗵 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number

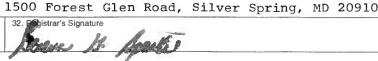
Registrar

31. Date filed (Month, Day, Year) MAR 2 9 2007

Jøgi, M.D.

30. Name and ac

Vikás/



ess of person who completed cause of death (Item 23a) (Type, Print)

D64174

29d. Date signed (Month, Day, Year)

March 28, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day March 27, 11:30a M 2007 \mathbf{V} Salsberry Clara 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Washington Adventist Hospital

ocial Security Number 6. Sex 7. Age (In yrs. last birthday) Takoma Park
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Days Months Hours Min 1 ☐ M 2 反 F Oct. 8, 1920 213-12-1019 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Tes 2 No Maryland Prince George's Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3508 Perry Street 20712 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Specify: White 3^{*} Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary State Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ernest L. O'Roark Clara Clevetta Click 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 43 Nighthawk Drive, Sylva, North Carolina 28779 Andrew E. Capoccia/Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3, April 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 2007 Cheltenham, Maryland 21. Signature of Funeral Service Licensee Francis do Tins Funeral Home Inc. Lobos 500 University Blvd, W., Silver Spring, MD 20901 9 5 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final oronary Jum disease or condition resulting in death) day Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury wou that initiated events resulting in death) Last Due to (or as a consequence of): Year

Physician /Medical Examiner

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at

Directo

Funeral

þ

Completed

Be

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Menial Hygiene. and: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

ettending physician and for use as the burial-transit been signed by the should be detached

Examine Physician/Medical Completed by Be Medical Certification; To

2

or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

l	
ı	IF FEMALE:
	23b. Was decedent pregnant
	in the past 12 months?
	1 ☐ Yes 2 ☐ No
	9 Unknown

- 2	23c. If yes,	outcom	10	of pr	egr	nar	CY
	1 Li	ve birth		2 🗍	Fet	al	dé
		regnant		time	of	de	ath

ath	3 Ectopic pregnanc 5 Other (specify)

23d. Date of delivery		
Month	Day	

Part II. Other significant conditions of	contributing to death but not	resulting in the underlying	ig cause given in Part

23e. Did tobac	co use con	tribute to the cau	ise of death?
1 🗆 Yes	2 1 No	3 Probably	4 Unknown

5. Was case referred to medical				26. Place of Deat
examiner? 1 ☐ Yes 2 ☐ ₩0	Hospital:	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Ho

24a. Was an autopsy performed2	24b. Were autopsy findings available prior to completion of cause of death?
1□ Yes 2☑No	1 ☐ Yes 2 ₺ No
h (Check only one)	

	1 ☐ Yes 2 ☐	o	Hospital: 1 Impatient	2
27.	Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day Y	

6 Could not be determined

			1	
28b. Time of Injury		28c.	Injury at Work?	
, ,	М		1 🗌 Yes	2 🗆 No

g	н	ome	o ☐ Hesidence	6 Uother (Specify)	
		28d.	Describe how in	ury occurred	

29a. Certifier (Check only	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date a Madical Examinar: On the basis of examination and/or investigation, in my opinion, de	
one'	2 medical examinar. Of the dasis of examination article investigation, if my opinion, de	satir occurred at the time, date and place, and due to the oddso(s)

3 Suicide

4 | Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0,		and mariner stated.
29b. Signature	and title of certifier	
	$\langle \cdot \rangle = \langle \cdot \rangle$	~

D14876

29d. Date signed (Month, Day, Year)

DION CHO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH Gupta, M.D. 4701 Randolph Rd., Rockville, MD 20852

Registrar

31. Date filed (Month, Day, Year)



After the funeral

death filled in by the fo

within 24 hours after To the Funerel Dire To the Hospitai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 2. Date of Death Month Vear **Physician** SARTER 03 1922 2007 28 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisbury Hospice at the Lake Wicomico Coastal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 **∑X**M 2 □ F Months Hours 062-16-5743 86 Director 01 03 1921 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene.

ans: If item 27 is marked other than "natural", or Items 23a or 28a-f show ans: If item 27 is marked other than "natural", or Items 23a or 28a-f show hirt item (and item of the Madical Examiner must be notified at ury or other traumatic event, the Madical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show Iner must be notified at 1 X Yes 2 □ No **Funeral Director** MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA 6 Mayflower Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. Armed Forces?
1 ⊠Yes 2 □ No AirIf Yes, Give Force
Year or Dates: WWII 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Firemen NYC Fire Dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward Adam Sarter Catherine Anna Grimm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 6 Mayflower Court, Berlin, MD 21811 Dorothy Sarter (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem. 4/2/2007 Crownsville, MD 22. Name and Address of Facility The Burbage Funeral Home eral Service Licensee 108 William St., Berlin, MD 21811 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner The law requires that the death certificate be executed ending physician and use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 □ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page certificate 1□ Yes Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 27 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural Injury 5 ☐ Pending investigation (Month, Day Year) М 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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			For State	State of Ma	aryland			Health and I	Mental Hy	giene	7 11700
2.4		-	Registrar 1. Decedent's Name (First, Middle, L	25 (1)		Cei	rtificate of	Death	2. Date of De	Reg. No	3. Time of Death
	Physici /Medic		Helen	Mary	Sh	erid	an		Month March	25 2007	
	Examin		4a. Facility Name (If not institution, g	4 4 4 4 4				or Location of Death		4c. County of D	eath
	* *		Calvert County 1 5. Social Security Number 6.		nter e (In yrs. las	t hirthday	Prince If Under 1 Year	Frederic		Calver	
7"	Funeral Director		275–20–9152	1 M 2 M F 7. Ag	93	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Birthplace (State or Foreign Country) ennsvlvania
No. 5	D		Usual Residence of Decedent			Town or Lo	antin-		Daii.	J, IJI 4 FC	
	/aryla f shov ed at	ō	10a. State 10b. County MD Calve	rt		nting					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-	Director	10e. Street and Number		1100		10f. Zip Code			10g. Citizen of What	Country?
	th with		121 Cox Road				206	39		U.S.	Α.
	er dea items ner mi	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - A Black, V	merican Indian, /hite, etc.
36	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 No	Specify:		Specify: 1	white
ည်	72 hornatura	Completed	15. Decedent's (Specify only highest of	Education rade completed)		16a. Dece	dent's Usual Occup	pation during most of word d)	kina	16b. Kind of Busine	ess/Industry
121	within ene. than '	dmo	Elementary/Secondary (0-12)	College (1-4or 5	i+)			d)		public s	ahool
0 0	i Hygi other ent, ti	Be Co	17. Father's Name (First, Middle, La			LE	acher	18. Mother's Nam	ne (First, Middle,	, Maiden Surname)	CHOOL
ylar	12 should be f n and Mental I ls marked of raumatic eve	To B	Eugene Thomas	Sheridan				Mary	Elizabe	th Seab	olt
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importantent of Health and Mental Hygiene. Interact 1st marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship							er, City or Town, Stat	'e, Zip Code)
<u>ة</u>	s 1 and f Health tem 27 other tr		Lawrence M. DiMa 20a. Method of Disposition	rco, nephev	20b. Plac		OX Rd., sition (Name of natory or other pla-	Huntingto	Date MD	20639 20c. Location - City	or Town, State
E O	Pages nent of h ant: If ite		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec			rrect	ion Ceme	tery 03/3	31/2007	Clinton, I	MD
Salt	permit. Departr Imports any Inju		21_Signature of Funeral Service Lic	ensee		22	. Name and Addre	ess of Facility Rau	isch Fun	meral Home	, P.A.
	<u></u> ≈ 0		222 Part Enter the disease or co	mulications that caused	the death	83	25 Mt. H	armony La	ine, Uwi	ngs, MD Z	0736 Approximate
	Physician		23a. Parl1. Enter the disease, or co shock, or hear failure. List on Immediate Cause (Final	y one cause on each lin	ne.	/	Daman	1.	or respiratory a	nest,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequer	nce of):	Dman	Me_			
- B	Examiner	L	Sequentially list conditions,	b							
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce <i>o</i> t}:					
60,	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):					
	ate be thysicia the bu	Physician/Medical		d							
. Box 687	The law requires that the death certificate b tee has been signed by the attending physic age 2 should be detached for use as the b	/Med	IF FEMALE:	23c. If yes, outcome	of pregnanc	:v				02d Date of	de live e
. B	death e atter id for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No	1□Live birth 4□Pregnant at	2 Fetal de	eath 3]Ectopic pregnanc] Other <i>(specify)</i> _	у		23d. Date of Month	Day Year
0.	ires that the de signed by the s be detached	Phys	9 □ Unknown `	9∐Unknown				F1. = 2			
Vital Records, P.	signer be d		Part II. Other significant conditions			_	1 Nygar		23e. Dia to		e to the cause of death? Probably 4 Unknown
CO	w require been signal	Completed by		SCILORES	,		1 NYGGA	101131001	24a. Was		autopsy findings available
He	sician: The law certificate has bi irector, page 2 s	ошо							autor perfo		to completion of cause of
/ita	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Dea			
0	Physical this caral direction	٠ <u>.</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatie	nt 2 EP	NOutpatien 8b. Time of		Nursing H		dence 6 Other (S	Specify)
0	nding ath. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	Year)	Injury	Wor	k? Yes 2 □ No	Zod. Describe i	now injury occurred	
Division or	or Atte ter dea irecto irecto	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home c. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and Number or vn, State)	Rural Route Number,
	pital o		29a. Certifier 1 Certifying F	hysician: To the best	of my knowle	odga doath	a cocurred at the ti	me date and place	amel dive de de c		
:	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director; p	edical	(Check only 2 Medical Ex-	aminer: On the basis of and manner sta	f examinatioı	n and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and place, and	due to the cause(s)
	vithiir To th	Me	29b. Signature and title of certifier		,		29c. Licens			29d. Date signed (M	onth, Day, Year)
	1		Illyons Co	Mels	wo		250	y 3 3 3		3/26/0	'7
١	1		30. Name and address of person wh	o completed cause of d ののり、イイの	eath (Item 23	3a) (Type, 1	Print)	133 1, SUITES	PR PR	INCE FRE	2621(16,40 578
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	e	1	, ,)	,,0	~~(- / 3
Divis	Registr	ar	MAR 2 9 2007	Brown 1	The state of the s	300					

State Registrar 3169

BRANGETON ST

EDGEWATER MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2007

AMOND

31. Date filed (Month, Day, Year)

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MAR 2

BANFER MO

egistrar's Signature

			1 - For State of Maryland / Dep State Registrar Ce	artment of Health and M		/	11722
			Hegistrar 1. Decedent's Name (First, Middle, Last)	runcate of Beaut	2. Date of Death	J. No	3. Time of Death
	Physicia		Eliza Thompson		Month March	Day Year 2007	
1	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	rai Cii	4c. County of Deal	
		•	1320 Forest Dr.	Annapolis		Anne Aru	ınde1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		8. Date of Birth (Month, Day, Y	9. Birl	thplace (State or Foreign
L	Director		212-32-9941 // //				ryland
	and w t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
	Mary -f sho fied a	to	Maryland Anne Arundel Annapo	olis			1 □XYes 2 □ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Co	ountry?
	th wit	alD	1320 Forest Dr.	21403		USA	
	ems er m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s afte ; or it amin	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ₹ No If Yes, Give Year or Dates:	1 ☐ Yes 🎢 No Specify:		Specify: B1	
21215-0036	hour tural	q pe		edent's Usual Occupation	16	b. Kind of Business	/Industry
5	in 72 n "na Aedic	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of workir DO NOT use retired)	ng	b. Killo of Dasificas/	madaty
212	d with giene r tha	E O	Elementary/Secondary (0-12) College (1-4or 5+) Hou	ısekeeper	P	rivate E	Family
D	al Hy l othe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Surname)	•
yla	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show farmmarke event, the Medical Examiner must be notified at	힏	Robert Foote Sr.	Eliza B	enton		
Jar	2 sh and is m			ing Address (Street and Number or Rura			
e, l	1 and Health		Della F. Parker(Daughter) 1320	Forest Dr. Ann		Md . 214 Oc. Location - City or	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 □ Cremation 3 □ Removal from State Chapter, cre	matory or other place) IM Church 3-30		est Rive	
量	artme ortani Injury		4 Donation 3 Dother (Specify)	Pan Name Ring Address of Eacility Ons			
Ba	permi Depa Impo any Ir			21 West St. Ann			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		146		Approximate Interval Between
d	Physician		Immediate Cause (Final disease or condition	emia			Onset and Death One Month
1	/Medical		resulting in death) Due to (or as a consequence of):				THE WIDTING
R	Examiner		Sequentially list conditions b. Poly Nouronal M	ultiplex			Twelve years
Ä	pa sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				Twelve Years
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8760,	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	ical E					
1 89	ificate g phy as the		U				
Box 6	death certifica attending ph	Z V	IF FEMALE: 23c. If yes, outcome pf pregnancy 1	Ectopic pregnancy		23d. Date of del	livery
	e deat	Physician/Mec	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
P.0	at the 1 by th etach	Phy	9 Li Onknown		T		
	tuires that the de n signed by the a lld be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.			o the cause of death?
Vital Records,	w requir been si should	Completed					
3ec	has k	mple			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
<u></u>	stcian: The certificate his rector, page		25. Was case referred to medical		1 Yes 2.	No 1 ☐ Yes	2 □ No
5	rslcia s cert lirecte	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death		ce 6 □Other (Spe	nife)
0	Attending Physician: r death. ector: After this certifics by the funeral director, p	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		City)
<u>ö</u>	ath. ath. or: Aff	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division or	or Attencter death irector: n by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	urs af		450 474				
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, deat (Check only one) 1 ★ Certifying Physician: To the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Mont	th, Day, Year)
	هدی		1 Offer Sun	038563	m.	arch 2710	2007
•	5		30 Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
			Wayne Bribau ~, 134 OWENSVI	16 Kead, West V	Siver, Mi	1 20	718
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8 2007	Print) Read, West (

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year OLSUN 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 577–34–2192 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 MM 2 F 10,1928 Washington,DC 78 November Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 10d. Inside City Limits Anne Arundel Edgewater Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 21037 USA 202 Holly Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑Yes 2□No Korea If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Electrical Contractor Graphic Arts item 27 is marked other other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file tment of Health and Mental H-tant: If item 27 Is marked oth jury or other traumatic even Be Dorothy Alberta Cole Joseph Albert Tolson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol B. Tolson - Wife 202 Holly Rd., Edgewater, MD 21037 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3/29/2007 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury o Lakemont Memorial Gdns. 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD 21. Signature of Juneral Salvice Lens George P. Kalas Funeral Home, P.A. ELLI MMI 0 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a ty, learning to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s 1□ Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: a No 1 ☐ Yes 1 🖍 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Da te of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending (Month, Day Year) 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. by the 24 hours after deat 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifler completely (Check only within 2 29b. Signature and title of certified 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) 31. Date filed (Month, Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

2007

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ATLEEN ARDIS 4a: Facility Name (M not institution, phrs			Ab. CR	y. Town, or	Location of De	eth.		Le. Court	y of Death	
Hartley Hall Nurs			Poc	omoke	City			Word	ester	<u> </u>
5. Social Security Number 8. 84	AM 7, Age	(hr yrs. tast bless	day) HUAG	91 1 Year	Hunder 24 H	A MACRITY	Day Ye	v/)	Cou	olsoe (Stelle or Foreign
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10a, State 10b, County		10c. City, Town								WOYas 2 Na
MD Worcester	r .	Pocomok							115-1-5-	-1-2
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	and to Im an		••							
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27. Manner of Death 1 Diffestoral 5 Pending 2 Assistant 3 Studden 3 Studden 4 Could not be determined 4 Hernicide 1 Countying Process Charle only 2 Martined Emmons 200. Certifier 1 Countying Process 200. Signature And this of certifier	28s. Date of Inju	ry Year) 29b. T	drish drish	28s Injur	7,81 7,81	289. U680	क्षेत्र । जीव्य ।	-le à acc	-1104	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Dorothy Eleanor Williams 12:30 PM 2007 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Julia Manor Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days Hours 05/09/1925 215-20-5970 81 Yrs Director MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is markad other than "natural", or Items 23a or 28a-1 show injury or othar traumatic evant, the Medical Examinat must be natified at MD Washington Hagerstown 1 TYYes 2 □ No Director 10e. Street and Number 10f. Zip Code 21742 10g. Citizen of What Country? 1521 Kensington Drive US Funerai death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is markad other than "na any injury or other traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James William Howard Edna Mae Dawson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet L. Wolf / Daughter 1515 Kensington Drive, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 04/02/2007 Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebra /Medical Due to (or as a consequence of), Examiner RM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 ☐ Yes 1 Yes 2 No 212 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred al or Attending P after death. I Director: After t d in by the funera 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 10, Ruth E. Alley April 2007 8:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 133 4th Avenue Lansdowne Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2₽F 220-24-4156 96 Director Jan. 31 1911 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. Cify, Town or Location 10d. Inside City Limits ms 23a or 28a-f shormust be notified at 1 ☐ Yes 2√2 No Maryland Baltimore Director Lansdowne 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 4th Avenue 21227 USA Funeral item 27 Is marked other than "natural", or items other traumatic event, the Medical Examiner mi 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental I Benjamin F. Arnold Clara B. Wyatt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce M. Landgraf / Daughter 37036 Pintail Drive, Selbyville, De. 19975 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery **4**☐Bonation 5 ☐ Other (Specify) 4/14/2007 | Brooklyn Park, Md. 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21 Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Md. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC COLON **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one) examiner? Daughe 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of Home Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1XXNatural (Month, Day Year) 5 Pending ours after death.

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filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 To the Hospital o within 24 hours aft To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) 900 CATON AVE BALTIMORE MD 21229 AGNES E.W. COLE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 3 2007

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 20b, per FH, g866, 4/24/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician Year John P. Brown 04 07 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chesapeake Medical Center Bel Hartord Date of Birth (Manth, Day, Year) 9. Birthplace (State or Foreign Country) Alabama. If Under 1 Year
Months Days **Funeral** Days 1**X**M 2□F 420.40.4506 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Hartord 1 ☐ Yes 2 No MD Joppa Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code T is marked other than "natural", or items 23a or traumatic event, the M-dical Examiner must be 226 Powdersh 21085 USA Koad Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 10/07 /0/4 Ω_{M} limgre, Maryland 21215-0036 þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
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1 ☐ Yes 2 No 24a. Was an certificate has autopsy 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA ٩ Date of Injury (Month, Day Year) 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ORLA

State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav 2215 BARRACATO 2007 /Medical WANDA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMOZE MARIN UNIVERSIL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign
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1 ☐ Yes 2 ☐ No s certificate has t lirector, page 2 s autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 ER/Outpatient 3 □ DOA P 1 Inpatient eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of Injury at 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 11, 2007 18594 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIND Esway5

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

2007

32. Registrar's Signature

State of Maryland / Department of Health and Me 1 - State Registrar Certificate of Death	ental Hygiene 007 11730
1. Decedent's Name (First, Middle, Last) Physician Louise Baker	2. Date of Death Month Day Year O O O O O O O O O O O O O
/Medical	4c. County of Death
Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Manor Care Woodbridge Valley Catonsville	Baltimore
	8. Date of Birth (Month, Day, Year) June 24, 1910 9. Birthplace (State or Foreign Country)
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Ellicott City	1 □ Yes 2√2 No
10e. Street and Number	10g. Citizen of What Country?
4014 Font Hill Drive 21042	USA
Total Band And And And And And And And And And A	ify Yes or No- lican, etc.) 14. Race - Americen Indian, Black, White, etc. Specify: White
Secondary (0-12) Secondary (16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Syears 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSewife HOUSewife	g
N 8 years Housewife	Own Home
Elementary/Secondary (0-12) Solution Solutio	(First, Middle, Maiden Surname) Holtzimer
Louis Korn Catherine Cath	
	llicott City, MD. 21042
20a. Method of Disposition Section Completely Compl	1ta 4 20c. Location - City or Town, State
1 XBurial 2 Cremation 3 Removal from State Baltimore Cemetery 2007	
	ne Of Dundalk,P.A. Road, Dundalk,Md. 21222
23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest, Approximate Interval Between
Immediate Cause (Final disease or condition a. CORUNARY ARTELY DISEA PROPERTY OF A CORUNARY ARTELY DISEA	Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	
Sequentially list conditions b.	
F. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	
that initiated events resulting in death) Last Due to (or as a consequence of):	
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
Note the part of the part 12 months? Continue to the part of the part 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 3 □ Ectop	23d. Date of delivery Month Day Year
O of the point of	
State of the stat	23e. Did tobacco use contribute to the cause of death?
PARUXY > MAL ATRIAL FIBRILLATION	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
The law requires grant age of speed age to the law requires grant age of the law requires grant age of the law requires grant age of the law requires grant age of the law requires grant age of the law requires grant age of the law requires grant age of the law requirements age of t	24a. Was an 24b. Were autopsy findings available
The law law law law law law law law law law	autopsy performed? death? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No
The part of the pa	(Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom.	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 28a. Date of Injury 28b. Time of 28b.	3d. Describe how injury occurred
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homology of Person of Peath 1 Page 19 Person of Peath 1 Page 19 Person of Peath 1 Page 19 Pending 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Seemined 288. Place of Injury - At home, farm, street, factory, office 289. Place of Injury - At home, farm, stre	3f. Location (Street and Number or Rural Route Number,
27. Manner of Death 1	City or Town, State)
The standard of the standard o	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
	29d. Date signed (Month, Day, Year)
D0059107	04-12-2007
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KALU UMA 210 Business (EMTER DRIVE RENSTE)	RSTOWN MD 21136
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** BROWN APRIL 11, Year 10 6:15p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE CATONSVILLE COMMONS NURSING CENTER CATONSVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 12-30-1945 **Funeral** 1 □ M 2 1 F Days Hours Yrs. Director 218-44-3616 Usual Residence of Decedent death with the Maryland 10a State Show 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Directo MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4031 CEDARDALE RD. 21215 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZÃNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int If item 27 Ie marked other than "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12-REGISTERED NURSE HEALTHCARE or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELLIS P. COCKRELL VIRGINIA BISHOP 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GILDA EXUM(SISTER) 5404 TODD AVE BALTIMORE, MARYLAND 21206 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 TCremation 3 Removal from State permit. Pagé Department of Important: If any injury or once. METRO CREMATORY 4-18-2007 BALTIMORE, MARYLAND * 4 ☐ Donation /5 ☐ Other (Specify) MHTANOL , D. HIBNERName and Address of FacilityPHILLIPS FUNERAL HOME, P.A. 21. Signature of Juneral 9 rvice 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1, Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shockly of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final reprovescu **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Š signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 8 1 Yes 2 No 3 Probably 4 Hrknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifice director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Tersing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗌 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 6942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Rd. Catangrille, MD 21228 100 32. Register's Signature State Registrar

			For State	State of	Marylan		rtment of H		ınd Mer	, ,	600	0007		722
			Registrar 1. Decedent's Name (First, Middle, Las	<i>t</i>)		Cei	IIIICALE OI L	Jealii		Date of Dea	eg. No.	.UU1	3. Time o	f Death
	Physici	an	, , ,	,						Month pril	Day	Year	9:20	A M
	/Medic Examin		Louis V. Barbar 4a. Facility Name (If not institution, give				4b. City, Town, or	Location of		PLTT		County of Dea		A
1	LAGIIIII	C1	Gilchrist Center	For Hosp	oice		Towson				Ba	Baltimore		
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 2	Min	Date of Birth (Month, Day	Year)	9. Bir	thplace (State	or Foreign
	Director		210-40-1213	⊠ M 2□F	65	Yrs.	Months Days	riodis	0	3/08/	942		yland	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside C	ity Limits
	Maryli f sho ied at	ō	Maryland		Ba	ltimor	e						1 XX es	2 No
	the 28a-	Director	10e. Street and Number				10f. Zip Code			1	0g. Citiz	en of What Co	ountry?	
	n with		1025 Hewitt Way				21205	5			U.S.	.A.		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13. \	Vas Decedent of Hi f Yes, specify Cuba	ispanic Orig	gin? (Specify	/ Yes or No-	1	4. Race - Ame Black, Whit		
0	after or ite	F	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	⊠ No		☐ Yes 2⊠ No	Specify:	,, , , , , , , , , , , , , , , , , , , ,	, 0.0.,		C		
215-0036	ural",	d by	3 X Widowed 4 □ Divorced	Year or Date	es:	10- B	l#- II1 O	-4!			1	AAT	nite	
۲ ک	n 72 "nat	lete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	lent's Usual Occup: kind of work done o OO NOT use retired	ation during most 1)	of working	î.	TOD. NIII	d of Business	rindustry	
7.	withi iene. tha n	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		enance Te				Ba	ltimore	e City	Gov.
2	be filed within 72 hours after death with the Marylan Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (F	irst, Middle,				
<u>a</u>	uld be Venta rrked ric ev	To E	Louis V. Barbarin	0				Ida F	Riley					
Maryland 2	ges 1 and 2 should be filed wit t of Health and Mental Hygien If item 27 is marked other tha or other traumatic event, the		19a. Informant's Name/Relationship (1	g Address (Street a							
<u>ک</u>	and lealth m 27 her tr		Shelly Kizina (Da	ughter)	look D		Hewitt Wa	ay, Ba	altimo			and 212 sation - City or		
0	iges 1 nt of F if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		_{ate} c	emetery, crer	natory or other plac	· :				,		-
Baltimore,	it. Partmer rtant:		4 □ Donation 5 □ Other (Specifical States of the Control of the C		Bay	view C	rematory	Inc. 4	4/13/2	007 E			Maryla	
g	permit. Pages 1 Department of F Important: If ite any injury or ot once.				>	1	Name and Addres Bri 407 Old I	zdzir	ński F	unera]	Hor	ne, P.A	land 2	1221
۰	4	4	23a. Part: Enter the disease, or com shock, or heart failure. List only	olications that cau	sed the death	n. Do not ent	er the mode of dyin	g, such as	cardiac or re	espiratory arr	est,	A, Mary	Approxima Interval Be	te
	Physician	l II	Immed Cause (Final	one cause on eac		. 1 .	C. J.						Onset and	Death
)	/Medical		disease or condition resulting in death)	a. Due to (or	as a consequ	uence of):	really						WELS	
	Examiner		Sequentially list conditions,	b. esop	hagi	his	153						years	
	Po iii	iner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (di	es e copequ	uence of):							1	
٦,	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):								
8760,	ate be executed hysician and the burial-transit	alE		4										
98		edical		0							-1			
Rox	it the death certific by the attending pached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome pf pregna th 2 🗆 Feta		Ectopic pregnancy				2	3d. Date of de	livery	
	deat le atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		Other (specify)					Month	Day	Year
7 O	at the by the	hys	9 Unknown							00: B: II:				1
	w requires that s been signed t should be det	by	Part II. Other significant conditions of	ontributing to dea	th but not rest	uiting in the ui	ideriying cause giv	en in Part I.		23e. Dig to			o the cause of robably 4	Unknown
Ö	requi	eted											,	
Vital Records,	e law has b je 2 s	Completed		1						24a. Was a autop: perfor	sy	24b. Were a prior to death?	utopsy findings completion of	available cause of
<u></u>			OF Man ages referred to madical					P/		1□ Yes	2 2 No	1 ☐ Yes	s 2□No	
	sicia s certi lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Ing	natient 2□	ER/Outpatien	t 3 DOA Oth	or:		theck only or 5 Resid		Other (Spe	0160 1 1 2150	100
Ö	ding Phys h. After this funeral dir	n: To	27. Manner of Death	28a. Date of		28b. Time of Injury				l. Describe h			12 27 0 10 3/2	14
0	Attending death. sctor: Aft	atio	1 Matural 5 Pending 2 Accident investigation		Day Teal)	injury		Yes 2 □ î	No					
Division or	r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	Zoe. Flace 0	f injury - At ho g, etc. <i>(Specif</i> y	ome, farm, str y)	eet, factory, office		28f.	Location (S City or Tow		Number or A	ural Route Nu	mber,
	oital ours aff													
	To the Hospital or Attending Physician: within 24 hours after cleath. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) Certifying Ph 2 Medical Exar	niner: On the bas and manne	is of examina	wledge, deat tion and/or in	n occurred at the tirvestigation, in my o	ne, date an pinion, dea	id place, and ith occurred	at the time,	ause(s) date and	and manner a place, and du	s stated. e to the cause	(s)
	o the	Med	29b. Signature and title of certifier	and manne	i datou.		29c. Licens	e number		2	29d. Date	signed (Mon	th, Day, Year)	
	F > F 0		· Whan	Ms			DS	830-	3		AM	16 17	2007	
	0		30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)	_					,	
	10		AARON I CH	onies w	1 670	IN	Charles	24	To	NON	W)	2120	4	
	Sta		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signa	ture								
	Registi	ar v												

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of rtificate of		R	eg. No.	11733
	Physici	an	Decedent's Name (First, Middle, La					2. Date of Deat Month	Day Year	3. Time of Death
	/Medic Examin		Anne Nor 4a. Facility Name (If not institution, gi			4b. City, Town,	or Location of Deat	4	09 2007 4c. County of Deat	
	LAdillii	CI	5167 Terrace	Drive		Ba	ltimore		Balt	imore
	Funeral Director		219-14-1802	Sex 7. Age	(In yrs. last birthday) 83 Yrs.	If Under 1 Yea Months Days			Year) Co	nplace (State or Foreign untry) cyland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	the Marylar 28a-f ahow notified at	tor	MD Bal	timore	Balt	imore				1 ☐ Yes 2 X No
	or 28,	Direc	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	eath w	erai	5167 Terrac	e Dr.	ever in U.S. 13		1236	Specify Yes or No-	USA 14. Race - Ame	rican Indian
36	within 72 hours after death with the Maryland ene. 10. 11. 11. 11. 11. 11. 11. 1	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo	If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer o <i>Specify:</i>	to Rican, etc.)	Black, White	
0	72 hours natural',	ted	15. Decedent's E (Specify only highest gi	Education	16a. Dece	dent's Usual Occi	upation le during most of wo	rking	16b. Kind of Business/	Industry
121	within 7	Be Completed by	Elementary/Secondary (0-12)	College (1-4or 5	/ife.	DO NOT use retir	red)	, Airig	Stuart &	Company
d 2	Hiled Hygie other	e Co	17. Father's Name (First, Middle, Las	t)				me (First, Middle, I	Maiden Sumame)	
Vlar	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Men	To B	James J. But	:ta					McGinni:	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hc t Health and Mental Hygiene. Item 27 Is marked other than 'natur other traumatic avent, the Medical		19a. Informant's Name/Relationship Michele A. Bi						r, City or Town, State, 2 ore, MD 2	
Baltimore.	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any Injury or other tra		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Dispo Dulanes Memoria	osition (Name of matery or other of Valle	lace) Apr	CIT IS	20c. Location - City or	
I i i	it. Pagintmen rtant: njury		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Figheral Service Lice	ify)					Timonium	
Ba	Depa Impo any l		Mento B	111	E v	ans Fu Cremat	neral Ch ion Serv	napel } vices	8800 Harf arkville	21234
	Physician /Medical Examiner		23a. Part. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each lin	the death. Do not ene. a consequence of):	ter the mode of dy	ying, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
760.p		ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Emai Underflying Cause (Disease or injury that indiated events resulting in death) Last	c	a consequence of):					
P.O. Box 68	death cer e attendir id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnan	ncy		23d. Date of del Month	ivery Day Year
	ires thet signed b	Ď	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	inderlying cause g	given in Part I.		bacco use contribute to	the cause of death?
Division of Vital Records.	The law requir cate has been si page 2 should	Completed						24a. Was a autops perfor	med? death?	topsy findings available completion of cause of
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Magnitali		To		ath Check only on	De)	
of	Physi r this o	7.	1 ☐ Yes 2 No 27. Manner of D ath	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day		III 3LI DOA			ence 6 Other (Specow injury occurred	cify)
ion	nding Ph ath. r: After th	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury		/ork? ∐Yes 2∐No			
Divis	Anospital or Attand 24 hours after death Funeral Diractor: 4 etely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, st c. (Specify)	reet, factory, office	е	28f. Location (Si City or Town	treet and Number or Ru n, State)	iral Route Number,
	To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the	edicai C	29a. Certifier 1X Certifying F (Check only one) 2 Medical Exa	Physician: To the best of iminer: On the basis of and manner sta	examination and/or in	th occurred at the ovestigation, in my	time, date and place y opinion, death occi	e, and due to the curred at the time, d	ause(s) and manner as ate and place, and due	stated, to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	7.11	1	29c. Lice	nse number	2	9d. Date signed (Mont	h, Day, Year)
			1	416	160	DC	0039297	2	4/10/	07
	3		30. Name and address of person who	ompleted cause of de	Rd. (Type	Print)	MD 2	1254		
	Sta		31. Date filed (Month, Day, Year)	10	ar's Signature			to-		
1	Registi	ar	ADD 1 9 2	007	M. An	made B				

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 7

	•	For State Registrar	, , , , , , , , , , , , , , , , , , , ,	Cer	tificate of I	Death	Rec	1. No.	1 11/04
* v *		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Physicia /Medic	-	Madge Constance I	ennett				Month April	12, Year 200	7 3:15 A ^M
Examin		4a. Facility Name (If not institution, give stree	and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
		43 Bangert Avenue				ry Hall		Bal	timore
Funeral		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	rear) C	thplace (State or Foreign ountry)
Director		219-30-0689 Usual Residence of Decedent	² M ² 72	TIS.			Nov. 20,	1934	Maryland
land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Mary f sho	힏	Maryland Baltimo	ro		Por	ry Hall			1 □Yes 2X No
r 28a	Directo	10e. Street and Number	716		10f. Zip Code	Iy naii	100	J. Citizen of What C	ountry?
Mwith 3a or		43 Bangert Avenue			21	128		U.S.	Α.
deat	Funeral	11. Marital Status 12. V	/as Decedent Ever in U	.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame	erican Indian,
after or Ite		1 ☐ Never Married 2 ☐ Married 1	☐ Yes 2 📉 No Yes, Give		☐ Yes 2X No		riidari, etc.)	Black, Whi	ie, etc.
C 21213-UU36 filed with the Maryland filed within 72 hours after death with the Maryland Hygiene. Hygiene. wher than "natural", or flems 23a or 28a-f show after than "attural", or flems 23a or 28a-f show after the Medical Examiner must be notified at	d by	3 X Widowed 4 Divorced	ear or Dates:					- I	Vhite
"nat	Completed	15. Decedent's Educatio (Specify only highest grade cor	n npleted)	(Give	ent's Usual Occup kind of work done o OO NOT use retired	during most of wor	king 16	6b. Kind of Business	/Industry
withir ene.	d I	Elementary/Secondary (0-12) (0-12)	ollege (1-4or 5+)		Homemake	,		Own He	nme
filed War	ပို	17. Father's Name (First, Middle, Last)		I	TIOMEMAKE		e (First, Middle, Ma		
ld be ental ked c	To Be	William Albrecht				Re	berta Bel	11	
Shou and M mar	-	19a. Informant's Name/Relationship (Type. F	Print)	19b. Mailin	g Address (Street			City or Town, State,	Zip Code)
und 2 alth a 27 is er tra		Terry Bennett (Son)		2825	Longfell	ow Ct., A	Abingdon,	Maryland	21009
NOTE, MARYIANG 21215-UU36 ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notifiled at		20a. Method of Disposition	20b. F		sition (Name of natory or other plac			c. Location - City or	
Baltimore, Maryland 2. permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other tany injury or other traumatic event, the once.		1 X Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (<i>Specify</i>)	vai irom State		Cemetery		5/2007 B	altimore,	Maryland
alt rmit. spartr porta ny Inj		21. Signature of Funeral Service Licensee		22	. Name and Addres	ss of Facility Sch	nimunek Fu	ıneral Ho	mes
n age a a		Buen a. We	llen	97	05 Belai	r Road, I	Baltimore	, Maryland	1 21236
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ns that caused the deat use of each line,	h. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Metast	at.i	Lun	Caree	2		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	0				
	_	Sequentially list conditions, b.	Due to for as a novem	man offi					
sit de &	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a conseq	uerios ory:					
xecur al-trat	Examiner	that initiated events c	Due to (or as a conseq	uence of):			· · · · · · · · · · · · · · · · · · ·		
oblow, find the properties of the project of the pr		d							
ecords, P.O. Box os/bou, "executed law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit.	Medical				- 1,00				
DOX ath cert attendin for use		ZOD. Was decedent pregnant	yes, outcome pf pregna □Live birth 2 □ Feta		Ectopic pregnancy			23d. Date of de	livery
deat death	sicia	1 Nee 2 MNo	☐Pregnant at time of d		Other (specify)			Month	Day Year
w requires that the death ce been signed by the attendi should be detached for use	Physician/			1					
S, les the igned	by	Part V. Other significant conditions contribu	ting to death but not res	ullting in the ur	derlying cause give	en in Part I.	/		o the cause of death?
ecord law require as been sign 2 should the	ted	Aron c 099	tratio 1	ului	7 1,50	acy	Yes	2 No 3 P	robably 4 Unknown
law law asb	Completed	Millerogelevote	Cudova	sale	Yisier	n	24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
ltal Fr	ပ္ပ						performe 1□ Yes 2	death?	3 2 No
cian cian certifi	Be	25. Was case referred to medical examiner?			104		th (Check only one)		
Phys Phys this al dir	၉	I les zy	la. Date of Injury	ER/Outpatien 28b. Time of		4 LI Nursing H		ce 6 □Other (Spe	ecify)
ding ding After funer	<u>ö</u>	r ☐ Natural 5 ☐ Pending	(Month, Day Year)	Injury	Worl	yat ⟨? Yes 2∐No	28d. Describe how	injury occurred	
r Attending er death. irector: Afte	cat	3 Suicide 6 Could not be	e. Place of injury - At ho	ome. farm. stre		163 2 110	28f Location (Stre	et and Number or R	ural Route Number
after after din b	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)	,,		City or Town,	State)	arar riodic Harrison,
		29a. Certifier 1 CertifyIng Physicia (Check only 2 Medical Examiner:	1: To the best of my kno	wiedge, death	occurred at the tin	ne, date and place	and due to the cau	se(s) and manner a	s stated.
he Ho in 24 ihe Fu	edical		on the basis of examina and manner stated.	ition and/or inv	estigation, in my o	pinion, death occu	rred at the time, dat	e and place, and du	e to the cause(s)
To T Com	Σ	29b. Signature and title of certifier			29c. License	number	290	Date signed (Mon	th, Day, Year)
,		1 0/0	DUT	TOD	I H	2605	C 1/4	pour 13	5 6007
20		(30) Name and address of person who comple	ted cause of death (Item	1 23a) (Type, I	Print)	Co. 1	1/1 1	C/ 11	1117
Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signa	1508	5 usi her	5 Unite	i way &	agelied h	N
Registra		APR 1 3 2007	Contract 1	Good	W.		(
			-	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #24a, perMD, g866, 4/13/2007 Tertificate of Death

Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Burzio **Physician** 16:15 PN Pauline 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hookins If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Days Months 1 □ M 2/2 F 13 Yrs. March 22,1994 Virginia Director 224-71-1209 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Berryville 1√2 Yes 2 □ No Virginia Director Clarke 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 22611 11 Swan Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Student 6 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important; If item 27 is marked other any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Ann Via John Bret Burzio 2 19a. Informant's Name/Relationship (Type. Print) 11 Swan Avenue, Berryville, VA 22611 John Bret Burzio/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Green Hill Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State April 16 2007 Berryville, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Enders & Shirley Funeral Homes&Crematory 21. Signature of Funeral Service Licensee 1062 West Main Street Berryville, VA 22611 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heart disease Congenital 13 years Physician /Medical Due to (or a consequence of): 4 days Examiner edema Cerebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 Probably 4 Unknown 1 Tes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 has certificate XX Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 (Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

ar 31. Date filed (Month, Day, Year)

30. Name and address of



person who completed cause of death (Item 23a) (Type, Print)

600 N. Wolfe St Baltimore MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** Thomas Walter Bland, Sr. 10 5:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 88 577-12-5387 Director Apr. 9, 1919 D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Director Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 707 Maiden Choice Lane, 8G03 21228 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iten Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No White þ Specify: 3 Widowed 4 Divorced Completed than "natur the Medical B 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) the Gas service repairman Public Gas Co. 7 is marked other traumatic event, tl alth and Mental Hvr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked or any Injury or other traumatic eve Edward Rosemond Bland, Sr. Sadie Ardella Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Bland, Jr. / Son 1774 Nanticoke Road, Pasadena, Maryland 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Pk. 4/13/2007 Elkridge, Maryland 21. Ignature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ementions **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed and burial-tra Due to (or as a consequence of) physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 5 Pending investigation 1 Natural 2 ☐ Accident Injury the Funeral Director: After and the Funeral Director: After and the funeral filled in by the funeral f 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2. 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) m D

State Registrar 31. Date filed (Month, Day,

3

Maide

choico Lane

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

715

32. Registrar's Signature

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artmen			ind M		Reg. No.	2007	11737
	Physici	an	1 Decedent's Name (First, Middle, Last) Joseph Virgil Bad							2. Date of De Month	Day		3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give 14627 Deerhurst Te	street and number)				Location o		04		2007 County of Death ontgomer	
	Funeral Director		033 03 0010	7. Age	(In yrs. last birthday 91 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 5-7-1	iy, Year)	Cot	nplace (State or Foreign untry) York
	Maryland e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Montgome	ery	10c. City, Town or L								10d. Inside City Limits 1 ★ es 2 □ No
	h with the	al Director	10e. Street and Number 14627 Deerhurst Tet	race		10f. Zip					10g. Citiz	zen of What Cou	untry?
980	be filed within 72 hours after death with the Maryland stal Hygiene. od other than "natural", or lleme 23a or 28e-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Deves 2 No. No. No. No. No. No. No. No. No. No.	0	Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		14. Race - Amer Black, White Specif whi t	, etc.
Baltimore, Maryland 21215-0036	within 72 ho lene. 'than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		+) (Giv-	edent's Usua e kind of wor DO NOT us Sporta	k done d e retired)	uring most				nd of Business/l	
/land	should be filed ind Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) George Badinelli			*		18. Mother	r's Name	(First, Middle Lercar	, Maiden .		C I I I I I I I I I I I I I I I I I I I
e, Mary	is 1 and 2 should of Health and Meritem 27 is marketother traumatic		19a. Informant's Name/Relationship (Ty Joanna Badinelli/d 20a. Method of Disposition			3 McKi	sson		Apt.		ver	Town, State, Zo Spring, cation - City or T	MD 20906
timor	Page ment cant: If ant: If ury or		13 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		Gate of	matory or of Heaven	Ceme	tery	4-1			er Spri	
Ba	permit. Departi Import. any inj		21. Signature of Puneral Service License		250	2. Name and app Fu				Silv Svc 93	er S 3 Gi	pring, l	MD 20910
8760,42	Physician / Medical Examiner physician and Examiner physician and Examiner physician and physician are physician and physician are physician and physician are physician and physician are physician and physician are physician are properly and physician are physician ar	Ilcal Examiner	23a. Part1. Enter the disease, or complishock, or heart stallure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	bonsequence of): a consequence of): a consequence of):	NA r	T		Ur +B	e NOS			Approximate Interval Between Onset and Death
P.O. Box 6	ne death certifi the attending thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of the first side of the fir	2 Fetal death 3	⊒Ectopic pre ⊒ Other (spe					2	3d. Date of deliving Month	very Day Year
	w requires that the bean signed by should be detact	þ	Part II. Other significant conditions con	tributing to death bu	at not resulting in the	underlying ca	LIPS	n in Part J	ic ICle	ncy10	Yes 2	No 3 Pro	the cause of death? obably 4 □Unknown
of Vital Records,	The ate h page	e Completed	OF Was appropriate and to applicat							1 ☐ Yes	psy ormed? 2 No	prior to condeath?	opsy findings available ompletion of cause of
of Vit	Physician: this certifical director,	To Be	25. Was case referred to medical examiner? 1 Yes No	ospital:	nt 2 ER/Outpatie	nt 3□ DO	A Othe	~	of Death sing Hon	(Check only only only only only only only only		□Other (Spec	ify)
ion	Jing After fune	atlon:	27. Manner of Death 1) Naturat 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time (Year) Injury	of 28	3c. Injury Work 1 □ Y	at ? es 2 □ N		8d. Déscribe	how injury	occurred	
Division	in Diffe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	iry - At home, tarm, si . (Specify)	reet, factory	, office		2		Street and wn, State)		ral Route Number,
	he Hospitel n 24 hours in he Funerel pletely filled	edical	29a. Certifier Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier Certifying Physical Certifier Certi	sician: To the best of ner: On the basis of and manner sta	t my knowtedge, dea examination and/or in ted.	th occurred anvestigation,	t the time in my op	e, date and inion, deat	d place, a h occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	esi	MD	29c.	License	number 36	28			signed (Month)	
	20x.		30. Name and address of person who co					J. 4.	U				
	Sta Registr	_	Steven Kariya 1060. 31. Date filed (Month, Day, Year) APR 1 3 2	32. Registra	r's Signature	<u>Kensi</u>	ngto •	n, MD	208	95			

				State of Maryl				•	_	
			1 - State Registrar			rtificate of		Re	g. Nd.2 0 0 7	11738
	Physici	an	1. Decedent's Name (First, Middle, Last) Rosalind Ruth Brijb	Nassv				2. Date of Death Month	Day Year	3. Time of Death 4:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	or Location of Death	April_	10 2007 4c. County of Deat	
1		la la	1009 Evesham Ave.			Baltimo			N/A	
rgr	Funeral Director		220-00-2310	7. Age (In)	787 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, October 2	Year) Co	thplace (State or Foreign ountry) Guyana
	/land low		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation	<u> </u>			10d. Inside City Limits
	e Mar	ctor	Maryland N/A	I	Baltimor	е				1XXYes 2 □ No
	with the a or 21	Dire	1000 Free alsom Area			10f. Zip Code 21212		10	Og. Citizen of What Co United St	•
	death ms 23	neral	1009 Evesham Ave.	2. Was Decedent Ever i	n U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic svent, the Medical Examinar must be rigitled at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates:		1 ☐ Yes 2 X No		Mican, etc.)	Specify: Inc	e, etc. Iò-Guyanese
Baltimore, Maryland 21215-0036	in 72 ho n "natur dedical	Completed	15. Decedent's Educ. (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Usuat Occup kind of work done DO NOT use retire	oation during most of work d)	ing	16b. Kind of Business	/industry
212	y with	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	ho	memaker			own home	
and	be file ad oth sveni	Be	17. Father's Name (First, Middle, Last)	Ab 411	ما م		18. Mother's Nam			
Ĭ	should nd Mei mark imatic	ပ္	(unknown) 19a. Informant's Name/Relationship (Typ	Abdull		ng Address (Street	Miria and Number or Rur		Odullah City or Town, State, I	Zip Code)
Mag.	and 2 valth a n 27 ls er trau		Vijay Brijbasi/son			Evesham		altimore,	MD 2121	2
ore	ges 1 t of He if itan or oth		20a. Method of Disposition 1. X Burial 2 □ Cremation 3 □ Re	miloval mont State		osition (Name of matory or other pla	1		20c. Location - City or	
Ħ,	artmen artmen ortent: injury b.		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License	\mathbb{D}_1						e, Maryland
Ba	Depar Impor		Dohn O. Mitch	ell A	_	Mitche 6500	ell-Wiede York Rd.	feld Fune Baltim	eral Home, ore, MD 2	Inc. 1212
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Ś	luires that lhe de n signed by the a lid be detached l	d by Pł	Part II. Other significant conditions cont Osteoporosis, Conge	-		, ,	ven in Part I.		acco use contribute to	o the cause of death?
ecol	law require as been sig 2 should t	piete	Gastroesophageal Re	eflux disea	se,			24a. Was ar	v prior to	utopsy findings available completion of cause of
E E	: The law cate has	Сош	Peripheral Vascular	disease				perform 1 Yes 2	ned? death? !∭No 1 ☐ Yes	2 XX No
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Division of Vital Record	ding Phy th. After this funeral d	tion: To	27. Manner of Death 1 \(\bar{Y}\) Natural 5 \(\bar{P}\) Pending 2 \(\bar{A}\) Accident investigation	28a. Date of Injury (Month, Day Yea		f 28c. Inju		28d. Describe ho		клуј
Divisi	Hospitel or Attend 24 hours efter deatt Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st	reet, factory, office		28f. Location (Str City or Town	reet and Number or R. , State)	ural Route Number,
	To the Hospitel or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 X Certifying Physi (Check only 2 Medical Examin one)	ician: To the best of my er: On the basis of exan and manner stated.	knowledge, deat nination and/or in	h occurred at the ti vestigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	To the I	Me	29b. Signature and title of certifier	IP.	00,	29c. Licens			9d. Date signed (Mont	
,	^		30. Name and address of person who cor	noleted cause of death	(Itam 23a) 0000	- 1	54749		April 12,	2007
_	2		Allen Reilly, MD	4 East Ro	lling Cr	coss Road	Baltim	ore, MD	21228	
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 3 2007	32. Registrar's S	ignature	W.				

	100	 State Registrar Decedent's Name (First, Middle, Last, 			Certifica	ie oi L	- Calli	2. Date of De	Reg. No.		3. Time of Death
Physici	_	EVELYN BARBARA BAF		IDER				Month APRII	Day	Year 2007	5:40P ^M
/Medio Examin	~ 4	4a. Facility Name (If not institution, give			,	, Town, or Hamps	Location of Death		4c. C	County of Deat Baltim	h
Funeral Director		5. Social Security Number 6. Sec. 212 ~05 ~0018	M 2XF	7. Age (In yrs. last bi	rthday) If Under Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birt Co .915 Ma	hplace (State or Foreign untry) ryland
p ,		Usual Residence of Decedent 10a, State 10b, County	-	10c. City, Tow	n or Location						10d. Inside City Limits
Aaryla f shov ed at	ō	Maryland Baltimor	-6	Too. Only, Toll		ltimo	mo				1 □Yes 2 □No
r 28a- notif	rect	10e. Street and Number				ip Code	T.E.		10g. Citize	en of What Co	
th with	al D	2113 Oakland Rd.					21220)		USA	
tems terms	Funeral Director	11. Marital Status	Armed F		13. Was Dec	edent of His edify Cuba	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14	 Race - Ame Black, Whit 	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fleem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married X ☑ Widowed 4 ☐ Divorced	1 ∐ Yes If Yes, G Year or I	2 ₹ No ive Dates:	1 ☐ Yes	2 XX Io	Specify:			Specify:	White
"natu dical	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>		Decedent's Us (Give kind of w life. DO NOT	ork done d	uring most of wor	king	16b. Kind	d of Business/	Industry
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e filed al Hyg other rent, t	BeC	17. Father's Name (First, Middle, Last)	<u> </u>	7 • 	<u> Barre ro</u>		18. Mother's Nam	ne (First, Middle,	Maiden S	Gurname)	
Menta Menta arked atic ev	ToE	Thomas Borchardt					Mamie	Slifker			
2 sho		19a. Informant's Name/Relationship (Ty			9	,	nd Number or Ru				Zip Code)
1 and Healtl em 27		Barbara J. Wilson 20a. Method of Disposition	(Daugi	20b. Place o	of Disposition (Na	ame of	ld. Hamps	Date Date		LU/4 ation - City or	Town. State
ages ent of tt: If it y or o	9	X ₁ X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from	i State	ery, crematory or Land M.		1	R=07		more,	
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/Medical Examiner		resulting in deduct)	Due to	(or as a consequence							E
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nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregnancy					23	3d. Date of de	livery
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at the by the	hys	9 ☐ Unknown	9∐Unkr					-11			
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	b	Part II. Other significant conditions co	ntributing to o	death but not resulting	in the underlying	cause give	n in Part I.	23e. Did 1			o the cause of death? robably 4 □Unknown
s been si should	Completed							24a. Was		24b. Were a	utopsy findings available
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cian: ertifica ctor, j	Be C	25. Was case referred to medical examiner?				1.	26. Place of Dea		-		DAGGITTERS
ding Physician: The lav h. Affer this certificate has funeral director, page 2	2	1 Yes 2 No 27. Manner of Death	lospital: 1 ☐	Inpatient 2 ER/O	utpatient 3 ☐ D		4 □ Nursing H	ome 5 Resi			ecity) HOUSE.
ding h. After funer	tion:	1 Natural 5 Pending 2 Accident investigation	(Moi		Injury M	28c. Injury Work	? Yes 2∐No	28u. Describe	now injury	occurred	
Atten r deat ector: by the	Certification:	3 Suicide 6 Could not be determined		e of injury - At home, f	arm, street, facto	ry, office				Number or R	ural Route Number,
tal or s afte al Dir ed in l	Cert	4ITOTIICIde	Dulk	ding, etc. (Specify)				City or To	WII, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical		ner: On the	e best of my knowledg basis of examination a nner stated.							
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DHMH 17 Rev 1/2001

EVELYN & BARIENFELDIFF

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, <

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BROOKS 2 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BON SECOURS HO SPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 □ F Yrs. MD 30 1895 Director 402-42-4247 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 injury or other traumatic event, the Medkal Examiner must be no once. U.S.A. 21216 1314 North Bentalou Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∏Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Black Be Completed by X□ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic Worker 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hanna မ William Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leicester Ct, Owings Mills, Md 21117 Wallace Johnson-Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md 4/10/07 4 Donation 5 ☐ Other (Specify) Mt. Auburn 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1. Ener the disease, or complice shock, or heart failure. List only one Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificat 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier

State Registrar 2000 West Baltimore Street,

30. Name and add ss of person who completed cause of death (Item 23) (Type, Print)

P

Martina

APR 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month & **Physician** 8:05 AM Maritou D. Brooks APITI 2007 /Medical 4b. Çity, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harsord gurede Grace If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Y Jan. 28, 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday Year) 1948 **Funeral** Days Months 1 ☐ M 2 💆 F Maryland 59 212-50-3689 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland 10b. County ıral", or Items 23a or 28a-f show I Examiner must be notifled at 1 ☐ Yes 2 No Directo Maryland Edgewood Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 USA 2402 Roth Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. White \$ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Public School System School Teacher s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Idella Lorish William McKinley Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 2402 Roth Rd., Edgewood, Maryland 21040 Marion I. Brooks/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-14-07 Joppa, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mountain Christian 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P. A. (ussell) 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner SETEURE Sequentially list conditions, if any leading of interesting cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed COME KIN VASINI IN H.5 to 14 the burial-tran Due to (or as a consequence of) physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) o. 9□Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 WNo 1 ☐ Yes Vital Physician; 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director Be Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ဂ္ 1 ☐ Yes / 2 ☑ No 1 🔲 Inpatient ō 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Many r of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Division 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WN 5in 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

07-02663 Boris Averbukh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

MD BALTIMORE RANDALLSTOWN 1	is Averbukii		State of Maryland / Dep	partment of Health Ce <i>rtificate of Death</i>		, 0	200	7 1174						
## AFENDRIS APENDRIS		Decedent's Name (First, Middle,Last)	AVEDDI		2. Date of Death	1								
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218-35-1556 1\(\)	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday) If Under		. 8. Date of Birth								
10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lin 10d. Insi	Director				Days Hours Min	05/16/	1941 Foreig	untry)UKRAINE						
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Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	7 ≥ ≥ 5 8	Me	29b. Signature and title of certifier					nth, Day, Year)						
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30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	3				reet, Baltimore. M	D 21201								
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		tate	On Date Shadish of Day 1											

			1 - For State Registrar	State of Mary	•	artmer				Re	g, No.	7 11743			
	Physici	an	1. Decedent's Name (First, Middle, Las Hester	В		Balde	rson			Date of Death	10, 200,	3. Time of Death			
	/Medic	cal	4a. Facility Name (If not institution, give					Location o		April	4c. County of I				
	Examin	ier	1022 Cayer Drive					Burni			Anne Ar				
	Funeral Director		5. Social Security Number 6. Sec. 214 - 20 - 8257		yrs. last birthday Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. 8. [Min. 0	Date of Birth Month, Day, CTODEN	^{Year)} 1919	Birthplace (State or Foreign Country) Maryland			
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de de	death with the Maryland ms 23a or 28a-f ehow Final Le ricilited at		10e. Street and Number 1022 Cayer Drive	Apt. 909		10f. Zi	2106	1		10	g. Citizen of What Country?				
ILE IS-UUSO filed within 72 hours after death with the Marylan Hygiene. wher then "neturel; or ftems 23a or 28a-f ehow ont, the Modical Extrainet mast be notified at		by Funeral Director	1 Yes 2 LXNo Specify: 3 ☑ Widowed 4 □ Divorced Year or Dates:									14. Race - American Indian, Black, White, etc. Specify: White			
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~	traum		19a. Informant's Name/Relationship (7			-					•	or Town, State, Zip Code)			
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5 5	ath. r: Afte e fune	ation	Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	м		k? Yes 2 □ N		28d. Describe now injury occurred					
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70.4	within compl	₩.	29b. Signature and title of certifier			29	c. License	e number		29	d. Date signed (A	fonth, Day, Year)			
	7		San & Carrare M				0332	231			4/11/0-	7			
5			30. Name and address of person who of	ompleted cause of death	(Item 23a) (Type	Print)	10 1	Yorks	Pasa	aden	mo	2112			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	A Tra			1	- / 4/	+				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1115 Anna Blake 2007 4011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Peninsula Viconico Regional Salisbury Mediral Center 8. Date of Birth (Month, Day, Year) July 27, 1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Security Number 6 Sex **Funeral** Days Hours Min. Months 1 □ M 2 💢 F Maryland 85 218-20-5127 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mind. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Salisbury MD Wicomico Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21802 USA 200 Civic Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 11 Marital Status 1 □ Never Married 2 □ Married Specify: black 1 ☐ Yes 2 🖾 No Snecify: þ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 1111 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) housekeeping Ŕ unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21801 1405 Flamingo Drive Salisbury, MD Joyce Wilson/caregiver 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4□Donation 5₩Other (Specify) in starte 21. Signature of Funeral Sorvice Licensee Ronal Ld S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Couse (Final disease or o indition resulting in death) Physician 2016 /Medical Due to (or as a consequence of): Examiner sonag Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last of) Examiner requires that the death certificate be executed resio aswler the burial-tran and Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day for in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 26MO has been Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed 2 🗆 No 2 1 No 1 ☐ Yes der certificate UNQ or Attending Physician: 25. Was case referred to medic ... examiner? director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 1 🗌 Yes 2 No 2 ER/Outpatient 3□ DOA Medical Certification: To this Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation M 1 Yes 2 No 2 Accident death. within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)
Apr. 1 5 th 200 7 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month Day Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g866, 04/13/07dhb Reg. Ng/ 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Thomas Phillip Conway, Jr. Aor. 2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Jeneral 5. Social Security Number 24 Hrs Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 218-60-3288 54 May 25, 1952 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show e notified at 1 XYes 2 ☐ No Completed by Funeral Director MD N/ABaltimore filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 7 3330 Wilkens Avenue 21229 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or item Black. White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 🎾 No Specify. Specify: White 3 Widowed 4 Divorced timore, Maryland 21215-003 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) <u>Welder</u> <u>Bethleham Steel Co.</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Healt, if item 27 is marked of Thomas P. Conway, Sr. Marian Joslyn Mercer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Conway - Brother 2836 Alabama Avenue, Baltimore Highlands, MD 21227 permit, Pages 1 am Department of Heali Important; If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel
Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 XCremation 3 ☐ Removal from State 4-11-2007 5 ☐ Other (Specify) Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulpuhr Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Aspiration Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): FILLON WOLLD BY MEDICH ENMINES Examiner Airway bleeding if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed Possible bleeding from Scar tissue the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Tuberculosis IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4 Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be d Completed by 1 | Yes 2 | No 3 | Probably 4 | Johknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has lirector, page 2 s autopsy death?
1 ☐ Yes 1□ Yes 2 No 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation **Injury** 1 Yes 2 No neral Director: A filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatur

Maryland

General

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 11:05 A M 2007 April Jonathan Paul Casterline /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day, Year)
June 25, 1966 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. 1**X**]M 2□ F Months Days Hours Maryland Director 213-56-3474 40 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director Maryland | Baltimore Perry Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4606 Forge Acre Drive 21128 U. S. A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status Black, White, etc. event, the Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Investment nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Management Company Manager 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Dorothy C. Sueoka James L. Casterline injury or other traumatic 2 and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health In portant: If item 27 i 4606 Forge Acre Dr., Perry Hall, Maryland 21128 Mary T. Casterline (Wife) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/12/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, Maryland 21236 Sum a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Lio blastomA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No Vital Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို o 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Hospital or Attending 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the Fune completely fi and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 125205

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

N. Chales St. Balts - und

Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** LYNNE CAROL CONGDON APRIL 2007 1:55A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Towson Baltimore Date of Birth (Month, Day, Year) NOV. 15,1939 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 216-36-9399 67 Nov. Maryland Director Usual Residence of Decedent t be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 XNo Director Maryland Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 105 Lariat Rd. 21220~2140 USA the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 0. 1 ☐ Yes XX No Specify: 3 Specify: 3 ☐ Widowed 4 🖾 Divorced White natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. N/A Clerk Telephone Industry 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be and Mental Charles V. Daukshis Ethel M. Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trau Gail P. Diegelman (Sister) 1204 Tarrytown Lane Baltimore, Md. 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metro Crematory Inc. 4-16-07 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home the 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician GASTRIC CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month 5 ☐ Other (specify) 4□Pregnant at time of death P.O. 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1∐ Yes 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 ☐ Yes 2 😿 No 1 🔲 Inpatient ۵ 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: A etely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar TARIO MAHMOOD

APR 1

31. Date filed (Month, Day, Year)

2007

LYNNE CONGDON

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD.

32. Registrar's Signature

MD 21093

TIMONIUM,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DANIEL LEWIS CORKRAN APRIL 9 1731 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner UPPER CHESAPEAKE HARFORD COUNTY HARFORD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**X** M 2□ F 218-52-4192 58 Director Maryland Dec. 9.1948 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f sh notified 1 □ Yes 2 KTXNo Maryland Harford Forest Hill - Harford County Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be 1601 Deborah Court 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1√JYes 2 No If Yes, Give 1 Never Married 25 Married 4/9/07 /73/ Itimore Maryland 21215-0036 1 ☐ Yes 2**X**ONNo White Specify: 2 3 Widowed 4 Divorced Year or Dates "natural" Completed er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) Sheet Metal Mechanic Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce. Daniel L. Corkran, Sr. Constance Mangano ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Coke (Mother) 9413 Old Harford Rd. Baltimore, Md. 21234-1153 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-11-07 Baltimore, Md. Metro Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home Bal 7401 Belair Rd. Baltimore, Maryland assahn 21236 23a. Part1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** anc months disease or condition resulting in death) una /Medical Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ၉ 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Iniury 1 Natural To tree.

Within 24 hours after ucc...

To the Funeral Director: After the further in by the further 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 341 pper Chesapeake Dr Ste. 31 ria Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

			For State Registrar	otato or titally all	Ce	rtificate of	Death		Reg. No.	2007	11749			
	Physicia	an	Decedent's Name (First, Middle, La. NICHOLAS DRA			2. Date of De Month	Day	2007	3. Time of Death 3. 40 A M					
	/Medic		4a. Facilify Name (If not institution, give			4b. City, Town,	or Location of Deat		-	County of Death	0 1-1			
	4. T			AN HOSPITA			TIM DICE		45	O Pists	(0)			
	Funeral Director		, , , , , , , , , , , , , , , , , , , ,	Sex 7. Age (In yrs. 1 ▼ M 2□ F 88	Months Days			¹ , 491	8 Pennsy	lace (State or Foreign htry) Vania				
	fand bw tt		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											
	e Mary a-f sh	ctor	MD Ba	ltimore	P	arkvill	.e		1 □Yes 2XNo					
	3a or 28	Il Director	10e. Street and Number 3022 North Br	anch Lane		10f. Zip Code	1234		10g. Citiz	en of What Cour	ntry?			
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.))- 1	4. Race - Americ Black, White,				
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 3 Widowed 4 MDivorced	1 XYes 2 □ No If Yes, Give Year or Dates:	1 XYes 2 □ No If Yes, Give Year or Dates:		Specify:				ite			
5	"natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Occu	ipation during most of wo	rking		of Business/Ind or Vehi				
7	within lene. than he Me	dmc	Elementary/Secondary (0-12)	College (1-4or 5+) 2			Officer		1	inistrat				
2	e filed al Hyg other vent, t	Be C	17. Father's Name (First, Middle, Last,	-			18. Mother's Nar	me (First, Middle	, Maiden S	Surname)				
y	Duld by Menta	To E	Wasco Drabis	Colomb										
2	T and 2 should be filed within 1 and 2 should be filed within Heath and Mental Hygiene. Em 27 is marked other than ther traumatic event, the M		19a. Informant's Name/Relationship (Jean Sell-comp				t and Number or Re Branch							
, G	Pages 1 and nent of Health nt: if item 27 ry or other to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	osition (Name of matory or other pla		Date 0.7		cation - City or To				
	permit. Pag Department Important: i any Injury o		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Lice	37	2	11 Cerrete 2. Name and Addr	ess of Facility	4-07 880		lin, Pen ford Ro Ie,MD 2				
0	a ii De		Candiae h	ME Fundal		YANS FUN CREMA		۷۱۲۲۱۷		Lle,MD 2				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Do STAGE DEMENTIA											
	Physician /Medical													
	Examiner													
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence)	uence of):									
,	xecute and I-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):											
50,	rtificate be executed ng physician and as the burial-transit													
0	rtificat ng phy as the	Medical	IF FEMALE:											
	ath ce ttendii or use		23b. Was decedent pregnant in the past 12 months?	су		2	23d. Date of delivery Month Day Year							
;	the de	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at time of d 9∐Unknown	leain 51	Other (specify)								
'n	ss that gned b	by Pr	Part II. Other significant conditions	contributing to death but not res	ulting in the u	underlying cause g	iven in Part I.	23e. Did			he cause of death?			
SI CO	require sen siç rould b	ted !		1 🗆	1 Yes 2 10 M6 3 Probably 4 Unknown									
ב ט	has bu	Completed						24a. Was auto perf		24b. Were auto prior to co death?	psy findings available mpletion of cause of			
פ	an: The	(a)	25. Was case referred to medical				26. Place of De	1□ Yes	2 No	1 □ Yes	2 No			
>	nysicia nis cer direct	To B	examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 Hipatient 2	ER/Outpatie	nt 3□ DOA	thor			6 □Other (Specify)				
ng Phy After thi			27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	We		28d. Describe	how injury	occurred				
2	Attend death. ctor: /	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Loc							i Number or Run	al Route Number,			
2	s after ai Dire	Serti	4 Homicide determined determined determined building, etc. (Specify)											
	To the Hospital or Attending Physician: The law requires that the death oe within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	edical (hysician: To the best of my kno miner: On the basis of examina and manner stated.										
	To the within To the Comple	Med	29b. Signature and title of certifier				nse number		29d. Date	e signed (Month,				
			AT AT	7200174 PHY	SICIAN	Do	061935	j .	APR	16 10	2007			
	axl		30. Name and address of person who	completed cause of death (Item	n 23a) (Type	, Print) DA	1140	N.M.	D					
	Sta	ite	31. Date filed (Month, Pay, Year)	32. Registrar's Signa	ature,	hack's	> FILCIM		1-00					
		1	APKIJ	CUU!	10	THE PERSON NAMED IN								

07-02709

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John M. Daughtery State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day April 9, 2007 Medical Examiner 1859 hrs Daughtry John 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth (MM/DD/YYYY) 9. 8irthplace (State or **Funeral** oreian Director Hours Country) 3-28-1982 217-98-9048 1 XM 2 F 25 Yrs MD Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. County 10c. City. Town or Location s 23a or 28a-f show 1 X Yes 2 No NA Baltimore hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 103 S. Morley Street 21229 U S Α Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, must be 1 Never Married 2 Married Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Yes 9 3 Widowed 4 Divorced If Yes, Give Year Yes 2X No specify: Specify. Black "natural" δ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hou minen to Health and Mental Hygiene ritent: If item 27 is marked other than "nay or other transmatic event, the Medicial Exp. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City NA Solid Waste 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McNeil Venus Be John H. Daughtry, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 Shadyside Road Balto, MD 21218 Venus McNeil-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State timore, crematory or other place)
Woodlawn Cemetery 1 X 8urial 2 Cremation 3 Removal from State 4-14-2007 Balto Co, MD Donation 5 Other Specify: 9 22. Name and Address of Facility March 21. Signature of Funeral Service Licensee F/HEast 21202 1101 Ε. North Avenue Balto MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Madical Death a. Gunshot wound of torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last Due to (or as a consequence of): andtransi The law requires that the death certificate be executed Physician/Medical attending physician a UNPENDED AMENDED 68760 IF FFMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Year Live birth Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ 1 Yes 2 No 3 Probably 4 Unknown ď Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Fo the Hospital or Attending Physician: director of Vital Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes 2 No 28a. Date of Injury FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After Certification: Subject shot FOUND: Natural Division 1 Yes 2 ✔ No 5 Pending the Apr 9, 2007 1757 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 24 hours after 3 Could not be Suicide or Town, State) found 100 block S. Morley Street, Baltimore, MD determined Funeral 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 10, 2007 O.C.M.E. un 0 2e aushan 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. Assistant Medical Examiner 31. Date filed (Month 32 Registrar's Signature State 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 52 AM Araulo Evardo 2007 13 /Medical 4c. County of Death Jown, or Location of Death Facility Name (If not institution, give street and number 4b. City Examiner 8. Date of Birth (Month, Day, Year) If Under 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 XM 2 ☐ F August16,1950 Director 56 Philippines 217-53-6018 Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County show notified at Yes 2□No Havre De Grace Directo Harford Maryland 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be r 21078 Completed by Funeral 413 S. Stokes Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Asian Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Finance Economics permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event, the once. is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aurellano C. Evardo Felicitas Garcia မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stokes Street Havre De Grace, MD. 21078 Idjea Axtell / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/26/07 TalibonBohol, Phili-TalibonCemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009Harford Road Baltimore, Marylan 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. 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Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address zevela Rebistrar's Signature 31. Date filed (Month, Day, Year) State APR 13 200 Registrar

DHMH 17 Rev 1/2001

07-0	2707	

David K. Eberhart,	1-	For State	Sta	ate of	Maryla		-	ment of icate of			Menta	al Hy	giene	Reg. N	20	0	7 1 1 7	5
Physician/ Medical Examine	1	1. Decedent's Name (First, Middle,Last)									2	2. Date of D Month April 9, 1	Day	y Year		3. Time of Death 1720 hrs		
	4	a. Facility Name (if 8441 High R		-	reet and nu	ımber)		4	b. City, To Ellicott		cation of	Death			4c. County of Howard	Death		
Funeral Director		. Social Security Nu 216-78-12		6. Sex	2 F	7. Age (In 37		birthday) Yrs.	if Under Months		If Under : Hours	24Hrs. Min.	1		м/DD/YYYY) 1970	Foreign	nplace (State or n intry)Mary1ari	ıd
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Box 68760, e death certificate by the attending physic ed for use as the bun by sician/Mer	2	F FEMALE: 3b. Was decedent past 12 months? 1 Yes 2 N	?	ne	23c. If yes, 1 Live I 4 Pregr	birth nant at time		2 Fet	al death ner (Speci	3 [Ectopic	pregnar	ncy		Month		ay Year	
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K		30. Name and addre Tasha Gree			sistant N	Medical E	Examin	er 111	Penn S	treet, E	Baltimor	e, MD	21201					
Stat Registra	-	31. Date filed (Mont	h, Day, Year)	3 20	07 32. R	strar's S	Signature	y Ag	100									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State Pt Maryland / Department Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year FRIE SON CORLEAN **Physician** 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MD 31223 SALT MURT BON SECOURS HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days (Month, Day, Ye 10/10/1914 1 □ M 2 X F Yrs SC 92 217-38-0250 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral", or Items 23a or 28a-f shov Examiner must be notified at **Baltimore** 14 Yes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21216 3816 Bonner Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. other than "natural", or Ite 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 "natural", or Specify: Specify: African American Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) dietary restaurant 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi Health and Mental F is marked Nelson Frieson Rilla Frieson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3816 Bonner Road; Baltimore, Maryland 21216 Ratha Cooper / Daughter permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 01/27/2007 Arbutus Memorial Park Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Rome, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 638 N. Gilmor Street; Baltimore, Maryland 21217 Ones 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months?

1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death signed by the a d be detached for o Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NECOMPENSATED CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PULMONARY FIBROSTS - COAGULDRATHY 24b. Were autopsy findings available prior to completion of cause of death?

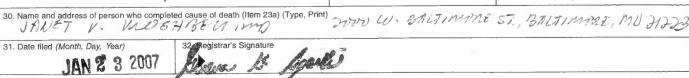
1 ☐ Yes 2 ☐ No 24a. Was an Urinary Tract Atherosclerotic Cardiovascular Disease, Infection Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: / d in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 🗌 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Janet U. maphoels, M.D JANUARY 19, 2007

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 3 2007



Jason Michael Fuhrmaneck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 April 11, **Physician** Michael Kevin Finegan 12:54A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brightwood Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□ F Months Days 225-44-7588 81 Director September 11,1925 Ireland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 560 West University Parkway 21210 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes XXNo
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Surgeon Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Finegan Katherine Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Lawrence Finegan Wife 560 West University Pkwy Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State I Burial 2 XX remation 3 □ Removal from State GreenMount Crematory 4/12/07 ☐Donation 5 ☐ Other (Specify) Baltimore, Maryland ignature of Funeral S 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc enny 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that in its and a second conditions). Due to for as a consequence of that initiated events nding physician and use as the burial-trar resulting in death) Last Due to (or as a consequence of) or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: ate has been signed by the attendir page 2 should be detached for use 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No certificate 1□ Yes 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No P 1 Inpatient 2 ER/Outpatient 3□ DOA this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16565N. Chaules Street 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 30 Month 03 Year **Physician** 0622 M /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Medical Center Anna poli Anne Arunde Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F 83 231-20-6019 3 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MANAKIN 10g. Citizen of What Country? 10e. Street and Number 1663 23103 USA 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖬 No Saltimore, Maryland 21215-0036 Specify BIACK Be Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CIGARette al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturer WOLKER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) of Health and Mental I thnie DICKERSON John Merini. Pages 1 and 2 sho. Department of Health and Important: If ten 27 any injury or 27 any injury or 27 any injury or 27 any injury or 27 any injury or 27 any injury or 27 any injury or 27 any injury or 27 any injury or 27 any injury or 27 any injury or 27 any injury or 27 any injury or 27 and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MANKIN Rd. MANAKIN SAbet, UA 23103 Fleming Son HERMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Green wood Memorial 4/4/07 RICHMOND, U.A. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. DAISNEY F. H. 21. Signature of Funeral Service Licensee 528 ASHLAND VA PO BOX 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician the the as IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the sahould be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has to page 2 s autopsv performed 2 X No After this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation To the recommend within 24 hours after death.

To the Funeral Director: After the funeral Director of the funeral Director of the funeral bush 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENSE m 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Marie 200 10 /Medical 4c. County of Death ity, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harbor Center N/A Birthplace (State or Foreign Country) If Unde 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Year Months Days Min 1 M 2 XF 214 54 7588 Yrs Virginia 58 14, 1949 Feb. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. Count 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Anne Arundel Baltimore Maryland Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 5107 Brookwood Road 21225 U.S.A 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. ould be filed within 72 hours after Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕱 No λq 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Janitorial Bingo World unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Andrew Asbury Novella Pennington ဥ of Health and Nitem 27 Is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruth Finley / Daughter 5107 Brookwood Road Baltimore, Maryland 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 4/11/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Fu neral Service License 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD untuo **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): physician Physician/Medical the 38 attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Year for Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by Completed by 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 1∏ Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 MER/Outpatient 3 □ DOA ပို 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After 1 Alatural 2 Accident (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours a

completely within 24 the

> 4 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21225

07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene
25 per me, g866, 04 612 07 dhb
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Green Feb. 14 2007 **Physician** Walter F. 8:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8001 Corkberry Lane Apt. 502 Anne Arundel County Pasadena If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Days Hours 1**X** M 2□ F **Director** 220-24-1463 74 Feb. 26,1932 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Anne Arundel <u>Pasadena</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 8001 Corkberry Lane Apt. 502 Funeral 21122 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. TYNYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married AXMarried 1948--Baltimore, Maryland 21215-0036 1 ☐ Yes 2\(\time{\chi}\)No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other thar other traumatic event, the M 12 Police Officer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Clifton Edna Green Shelden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8001 Corkberry Lane Apt 502 Pasadena, Maryland 21122 of Disposition (Name of Date 20c. Location - City or Town, State <u> Helen M. Green (Husband)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of P Important: If Ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2/19/2007 Brooklyn Park Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed PARAPARESIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZENO Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending 1 ∏Yes 2 ∏No investigation 2 Accident within 24 hours after death

To the Funeral Director:,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier FEBRUARY 15, 2007 21776 Villetie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITCHIE HIGHWAY PASADENA ZIKE SURYA MUNDRA MI) 8021 \$2. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

APR 1 2 2007

			1 - For State of Maryland / De Registrar	artment of H			giene 007	11759
	Discovering to the		Decedent's Name (First, Middle, Last)			2. Date of De Month		3. Time of Death
	Physici /Medic		Rodney William Graham			Apri	$1 11^{\text{Day}}, 200^{\text{Year}}$	8:40 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of De	
			Riverview Care Center	Essex			Baltimor	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10/30/	th 9. Bi	rthplace (State or Foreign country)
	Director		233–48–4818			10/30/	1933 We	st Virginia
	land ow		10a. State 10b. County 10c. City, Town	cation				10d. Inside City Limits
	Mary -f eh	to	Maryland Baltimore Middle	ver				1 ☐ Yes 2 🔀 No
	r 28a	irec	10e. Street and Number	10f. Zip Code			10g. Citizen of What C	country?
	h with	Funeral Director	1 Mercy Court	21220			U.S.A.	
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٥	or It	/Fu	1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No 1951 —	1 ☐ Yes 2 ☒ No		7 110411, 010.)	Black, Wh	
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9500-91212	be filed within 72 hours after death with the Marylan ital Hygliene. Id other then "natural", or iteme 23a or 28a-f ehow other then "natural", or iteme and itse notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (6	dent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of wor	king	16b. Kind of Busines	s/Industry
7	within 72 ene. then "nal he Msdic	m d	Elementary/Secondary (U-12) College (1-4or 5+)	phone Oper			Hospital	
	filed Hygi other	ပိ	17. Father's Name (First, Middle, Last)	none open		ne (First, Middle	, Maiden Sumame)	
Maryland	d be ental ked c	To Be	Russell William Graham		Bessie H	rice		
2	should be nd Mental marked c	-					er, City or Town, State,	Zip Code)
	permit. Peges 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked eny injury or other treumatic evones.		Wanda Snyder (Sister) 69	eppermint	Lane, Ba	ltimore	e, Maryland	21220
ē,	of Heal		camatani	sition (Name of natory or other place	a)	Date	20c. Location - City o	r Town, State
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<u>=</u>	partn porte y inju		21 Symilars Funeral Service Licensee	Name and Addres	s of Facility	Funera	al Home, P.	λ
n —	89 2 2 9	(407 Old E	Eastern A	venue,	Essex, Mar	yland 21221
			23a. Part Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	er the mode of dying	g, such as cardiac	or respiratory a	irrest,	Approximate Interval Between
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	/Medical Examiner		resulting in death) Due to (or as a consequence of			1-11		
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-	ed	Examiner	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury					
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-		=	V.					
POK PS	death certifica e att noing ph id for use as th	M/UI	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	Testania programa.			23d. Date of de	elivery
	death	sicia	1 Yes 2 No	Ectopic pregnancy Other (specify)			Month	Day Year
J O	et the i by the stach	Physician/Med	9 Unknown					
ś	The law requires thet the death certifica te has been signed by the attinding ph tage 2 should be detached to use as it	þ	Part II. Other significant conditions contributing to death but not resulting in t	nderlying cause give	n in Part I.		tobacco use contribute	
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VItal	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	Othe	26. Place of Dea			
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0	E 45 F	tlor	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) Inj	28c. Injury Work M 1 □ Y	? ′es 2 □ No		, , , , , , , , , , , , , , , , , , , ,	
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Ē	s afte	Certification:	4 Homicide building, etc. (Specify)			City or To	wn, State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier (Check only (Ch	n occurred at the tim	e, date and place	and due to the	cause(s) and manner a	is stated.
	the hain 24 the F	Medicai	one) and manner stated.					
	To To	-	29b. Signature and title of certifier M.D.	29c. License		74	29d. Date signed (Mor	
			IVUB	<u> </u>	20 T	7	04-12-	2007
	4+1		30. Name and address of person who completed cause of death (Item 23a) (T	EAS TR	RN !	BLUD	MD-2	2/22/
	Sta		31. Date filed (Month, Day, Year) APR 1 3 2007	E. J				
	Registr	ar	APR 1 3 2007					

State of Maryland / Department of Health and Mental Hygiene

1 - For State Amend #1, perMD, g866, 4/13/07 TT

Certificate of Decision of D Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Boris Geykhman Month Year **Physician** 2007 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral 1** M 2 □ F Months Days Hours Min ÚKRAINE Director 215-33-3171 01/31/1930 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2 X No MD BALTIMORE OWINGS MILLS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 PLEASANT RIDGE DRIVE APT. 118 21117 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ ENGINEER CLOTHING MANUFACTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SHIMON **GEYKHMAN** FAIGA SAPOZHNIKOVA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 PLEASANT RIDGE DRIVE #118-OWINGS MILLS, MD 21117 <u>ALLA GEYKHMAN / WIFE</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Degration 5 □ Other (Specify) 04/11/2007 REISTERSTOWN, MD BALTIMORE HEBREW of Funeral Service Gensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. physician s the buria as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year ō 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an cate has page 2 s autopsy this certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 2 ER/Outpatient P After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. To the Funeral Director completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide affer within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

9

DHMH 17 Rev 1/2001

State Registrar

negistiai

31. Date filed (Month, Day, Year)

NORTH

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WOLFE

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:00A M **Physician** 20827 Ceprel LeRov Gamse /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A 830 W. 40TH ST., APT 755 BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday Funeral 1**X** M 2□F 93 05/03/1913 MD 212-01-2561 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 □ No MD N/A BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21211 USA 830 W. 40TH ST., APT 755 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu, any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWNER GAMSE LITHOGRAPHING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **BENNO** GAMSE VIOLET FLUEGEL 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 830 W. 40TH ST., APT 755, BALTIMORE, ANN GAMSE / WIFE 20b. Place of Disposition (Name of OHEB SHALOM 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEMORIAL PARK 04/11/2007 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ischenue Physician /Medical Due to (or as a conse tience of): Years Examiner arter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons uence of) Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

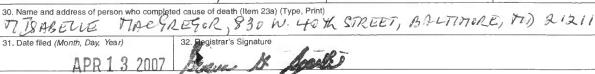
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s this certificate 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 26. Place of Death (Check only one, 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Mann f Death 1 Matural To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certified



D13657

29d. Date signed (Month, Day, Year)

			For State 1 = State Registrar		artment of Health and I rtificate of Death		giene leg. No. 200	7 11762
Е			Decedent's Name (First, Middle, Last)			2. Date of Dea Month_		3. Time of Death
	Physicia /Medic		Elbert J.	Hensley	-	April	08 2007	9:55 P M
	Examin	er	4a. Facility Name (If not institution, give street and 4300 Belle of Georgia		4b. City, Town, or Location of Death Pasadena	1	4c. County of Dea	ath Arundel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign country)
	Director		245-52-2614 ¹ ⋈ ^{M 2□}	F 70 Yrs.	Months Days Hours Min.	May 22	1936	NC NC
	w		Usual Residence of Decedent 10a. State 10b. Counfy	10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl f sho	tor	Maryland Anne Arunde	1	Pasadena			1 □Yes 2√ No
	or 28a	irec	10e. Street and Number	<u>'</u>	10f. Zip Code	1	10g. Citizen of What C	country?
	23a c	ral	4300 Belle of Georgia		21122		USA	
	er dez items ner m	Funeral Director	Arme	Decedent Ever in U.S. d Forces? les 2 ☑ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
Š	ırs aft al",or xaml	by	^ If Yes	, Give or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	White
5	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show afte event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade comple	red) i (Give	edent's Usual Occupation e kind of work done during most of wor	king i	16b. Kind of Business	s/Industry
7	vithin me. han "	mple		ife.	po NOT use retired) epair/Refinisher		Furniture	Company
7	filed v Hygie other 1	ပိ	17. Father's Name (First, Middle, Last)	I INC		ne (First, Middle,	Maiden Surname)	Company
0	Hental rked c	To Be	William Eugene	Hensley	Jennie	Ba	ıllard	
	2 shot and N ls ma		19a. Informant's Name/Relationship (Type. Print)	1	ing Address (Street and Number or Ru			
ຊ ນົ	1 and Health Pm 27 ther tr		Bonnie O. Hensley (20a. Method of Disposition		Belle of Georgia	Date	Pasadena, M	
2	ages ent of l t: If ite y or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal f	om State	osition (Name of ematory or other place) ematory Inc. 20		ŕ	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Livense		O Name and Address of Facility		Baltimore,	
ă	permit Depar Impor any Ir		1 By 2 8x		3111 Mountain Roa			1122
			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one dause		nter the mode of dying, such as cardiad	or respiratory arr	rest,	Approximate Interval Between Onset and Death
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	Examiner			s to (or as a someoquemes or).				
	D #	iner	cause. Enter Underlying	e to (or as a consequence of):				
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D	rtifical ng phy as th		IF FEMALE:					
Š	ath ce	ian/I	23b. Was decedent pregnant 1 LL		□Ectopic pregnancy		23d. Date of d	elivery Day Year
:	the de y the a	Physician/M		regnant at time of death 5 Inknown	Other (specify)			
Į.	ding Physician: The law requires that the death certificate be executed n. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	by Pr	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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Š	e law I has be	Completed				24a. Was a autop		autopsy findings available o completion of cause of
VII	n: Th ficate rr, pag		25. Was case referred to medical		00 Plans of Da		2 X No 1 □ Ye	
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2	l or A	Certification:	determined	ouilding, etc. (Specify)	treet, factory, office	City or Tow	n, State)	nurar noute Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fun	edical C	(Check only 2 Medical Examiner: On	he basis of examination and/or i	ath occurred at the time, date and place investigation, in my opinion, death occ			
	ro the vithin 2 or the omple	Med	20h Cignoture and title of portifier	manner stated.	29c. License number		29d. Date signed (Moi	nth, Day, Year)
27	~		Marko	MW.D	D39505		April 13,	2007
	V		30. Name and address of person who completed			MD O		
F	Sta	ite.	Yudhishtra Markan 31. Date filed (Month, Day, Year)	305 HOSPILAT 32. Registrar's Signature	Drive, Glen Burn	ie, MU Z	1001	
	Registi		NDO 1 2 2007	A Agen	R.F.			

Please Type	or Print in	Black Indelib	le Ink. E	Ensure All	Copies Ar	e Legible.
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			For State Registrar	State of Maryland		ırtment of ⊦ <i>tificate of i</i>		d Mental Hy	giene Reg. No. 2	007	11763
	Dharist		1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
	Physicia /Medic	- 6	David J.	Hart	man		Sr.	April	12, 20	07	2:05 A ^M
	Examin	er	4a. Facility Name (If not institution, give s Stella Maris — Tov			4b. City, Town, o		eatn		inty of Deatl timor e	
y	Funeral	6	Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 H Hours M		rth ay, Yea <i>r)</i>	9. Birtl	nplace (State or Foreign untry)
l _e	Director		217–62–5798 Usual Residence of Decedent	M 2 F 5	Yrs.			August 2	9,1955	Mar	yland
	yland now at		10a, State 10b. County	10c. City	Town or Lo	cation					10d. Inside City Limits
	ne Mar 8a-f sl	ctor	Maryland Baltimor	e	Dunda			-			1 ☐ Yes 2 X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amyn filury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 2106 Cameron Drive	Apt G.		10f. Zip Code 2122	2		10g. Citizen		untry?
	r deatl	ner	11. Waltar Glaco	2. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)		Race - Ame Black, White	rican Indian, e, etc.
36	irs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:		1□Yes 2XINo	Specify:		Spe	ecify: Wh	ite
Maryland 21215-0036	72 hou natura iical E		15. Decedent's Educ (Specify only highest grade	ation (completed)	(Give	dent's Usual Occup	durina most of v	working	16b. Kind o	of Business/	Industry
121	within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use retired all Insta	d) -		Const	ructi	on
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Mar	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship (Type	oe. Print) Daughter	1	•		Rural Route Numb Baltimo			•
ē,	f Healt frem 2		20a. Method of Disposition	20b. Pl		sition (Name of natory or other place		pril 16,	 		Town, State
imo	Page nent o ant: If		1 ☐ Burial 2 Mathemation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			Crematory	,E	07	Baltin	nore,	Maryland
Baltimore,	permit. Departr Importa any Inj once,		21. Signature of Funeral Service License	onnelly	71	Name and Address Onnelly F 110 Solle	ss of Facility Uneral rs Poin	Home Of I	Dundall Dundall	c,P.A.	21222
	*		23a. Part1. Enter the disease or complishock, or heart failure list only or	cations that caused the death e cause on each line.							Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	CHRONIC OBS		VE PULMO	NARY DI	SEASE			Onser and Beauty
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8760,	cate be executed physician and the burial-transit	dical E	d								
9	ertificat ing phy e as th	0 1	IF FEMALE:								
Вох	leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnal 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3	Ectopic pregnanc Other (specify)	у		23d.	Date of del Month	livery Day Year
o.	that the de led by the a detached f	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		2 0 11 01 (40 0 17) _					
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Vital Records,	w requir been si should	Completed			, , , , , , , , , , , , , , , , , , , ,				s an 2		utopsy findings available
Re	The la	фшо						— auto perl 1∐ Yes	opsy formed? 2X No	prior to death? 1 ☐ Yes	completion of cause of
/ita	Physician: The k this certificate ha ral director, page 2	Be C	25. Was case referred to medical examiner?	lospital:		Oth		Death (Check only	one)		
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ion	Attending r death. ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? Yes 2∐No				
Division or	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, sti	reet, factory, office		28f. Location City or To	(Street and Nown, State)	umber or Ri	ural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Co	29a. Certifier (Check only one) Certifying Physical Examinate (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, deat tion and/or ir	h occurred at the to	me, date and plopinion, death o	face, and due to the	e cause(s) an e, date and pla	d manner as ace, and due	s stated. e to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date s	igned (Mont	th, Day, Year)
	0		1/2			Dh	5721		4	1/12/	07
	4		30. Name and address of person who co				ͲͳϒΛΝΙΤΙΙ	Mr Mrn 917	าดจ	•	
	Sta	ate	DR. TARTO MAHMOOD 31. Date filed (Month, Day, Year) APR 1 3 7007	2300 DULANE 32. Registrar's Signa		ut I_KV.	TTIONIO	M, MD 210	173		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Day **Physician** 22:01 07, 2007 Susan Elizabeth Hayduk, D.M.D. April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Siani Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 06, 1945 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕅 E Yrs. 62 Paso, Texas Director 176-36-5150 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in then "naturel", or items 23s or 28s-f ehow the Medical Exeminer must be notified at 1 ☐ Yes 2X No Directo Baltimore County Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of 2324 Smith Ave. 21209 America Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐XMarried Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Dental School Dentist Educator 12 08 Deperment Pages 1 end 2 should be file.
Deperment of Heelth and Mantal Hydi.
Important: If tiem 2.7 is marked.
ony injury or other? 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Ellsworth Hayduk Amelia Patricia Kazak 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Irvin Sachs, D.D.S. Baltimore, Maryland 2324 Smith Ave. 21209 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) April 13, 2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium, Maryland 21093 ch, or yeart ailur r com it ations that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Lit only one cause or each line Immedia Cause (Final disease or condition resulting in death) ARRHYTHMIA **Physician** TRICULAR MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box $68760^{\prime\prime}_{\sim}$ Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HIGH NORMAL BLOOD PRESSURE 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2X No 1 Yes 2 □ No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 | Inpatient | SER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ၉ this After thi 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 TYes 2 TNo investigation Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) helsen, mo D 38327 April 10, 2007 rais C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 Lois E. Nielsen, M.D. 120 Sister Pierre Drive, #206, Towson, Maryland 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital of within 24 hours af To the Funeral Discompletely filled in

Helon, M. S. DØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 76.01 OSL 32. Registrar's Signature OSLER DRIVE TOWSON, MARYLAND 21204 ABDALLAH HELOU APRI 3 31. Date filed (Month State A Shipping Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 12 2007 Tiesson 6:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Pockway Beltan Pornin Parkuille If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 30, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 1 F 84 Baltimore, MD Yrs. 216-16-1551 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event. If a Madical Examiner must be notified at once. 1 ☐ Yes 2 No Maryland | Baltimore County Parkville Director 10e. Street and Number 10g, Citizen of What Country? 10f, Zip Code 1801 Wentworth Road 21234 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: Specify: 3 ☐Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Inventory Clerk Maryland State Police 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Julia Murphy Walter L. Rau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. William Hesson, Jr. (Son) 8508 Arry Place Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lorraine Park Cem. Woodlawn, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License eaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 Tork Road Timonium, maryland 21093 Into the classe, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or learn for ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Demenha glacis /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, of cause of the second o Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 3 Probably 4 □Unknown 1 Yes 2 No CHF been 24b. Were autopsy findings available prior to completion of cause of death? heart direct 24a. Was an page 2 autopsy performed? 25. Was case referred to medical examine? this certificate 2 No 1 Yes 2 ₹No 1 TYes O1Selsa or Attanding Physician: director, Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Tyes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 -Natural 1 ☐ Yes 2 ☐ No М 2 Accident Diractor: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely the state ş within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 D 71295 41,2107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 5+ Sute 4202 wid 21264 Charles Tousen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 27 **Physician** Sonia Diane Hall 2007 68 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 54125 AGNES HOSPITAL BALTIMOR E 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington, DC Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Unknown 1 □ M 2 🔀 F Months Hours 44 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ges 1 and 2 should be filed within 72 hours after death with the Maryla tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 28a-f show 1 TYes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 124 Randall Road U.S.A. 21230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XINo Black þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Raymond Hall Loretta Dawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Loretta Tate / Mother 708 James St. Syracuse, New York, 13203 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/04/07 Riverdale, MD Riverdale Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Hm 21. Signature of Juneral Service Licensee 108 W.North Ave. Baltimore, MD 21201 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) AIDS **Physician** HTGOW /Medical Due to (or as a consequence of): Examiner INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 Fetal death in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2□ No 3 Probably 4 Unknown Completed certificate has been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1□ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA 은 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: death in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō filled To the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 27, 2007 20656

Registrar

KONSTAL

31. Date filed (Month

APR

Year)

DHMH 17 Rev 1/2001

ELUITSKIY

32. Registrar's Signature

900 S.CAYON AVE, BALTIMORE, HDZIZE

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per doc 8866 4-25-07 vt.
State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 11 William J. Hanke William Gene 2007 9:35pm April Hanke 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7518 Schooner Lane Middle River If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sept. 4, 1951 Social Security Number 7. Age (In yrs. last birthday) 8. 9. Birthplace (State or Foreign 219-52-8152 **★**□ M 2□ F MAryland 55 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Middle River 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7518 Schooner Lane 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Moblie Mini 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glen HAnke Cecielia Gardener 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7518 Schooner Lane Baltimore MD 21220 Corrine Hanke /wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore MD 21. Signature of Foneral Service Licensee 22. Name and Address of Facility 300 Mace Ave, Balto. MD Kali 8 Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each lim. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): MD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

"natural", or items 23a or

the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any Injury or other traumatic event, the Me

filed within 72 hours after

Baltimore, Maryland 21215-0036

Directo

Funeral

à

Completed

Be

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MD

Examine burial-trai physician the as attending p for use as by the signed I this certificate Be Certification: To After 1

The law requires that the death certificate be executed

Physician:

death. Director:

fo the within 24 hour.
The Funeral Dire.

Box 68760,

Ö

۵.

or Vital Records,

Division Hospital or Attending Physician/Medical δ Completed 25. Was case referred to medical examiner?

IF FEMALE 23h. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

1 ☐ Yes 2 ☐ No

29a. Certifier

one)

(Check only

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No 1∐ Yes 26. Place of Death (Check only one)

27. Manner of Death 1 Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Tim Injui
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At he building, etc. (Specific	ome, farm,

Hospital:

28c. Injury at Work? 1 ☐ Yes 2 ☐ No street, factory, office

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

5 Residence 6 □Other (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 4 Nursing Home

29b. Signature and title of certifier

APR 13

D00375

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

QI VINI alle 31. Date filed (Month, Day, Year) 32 Segistrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death

Physician /Medical Examiner

Funeral Director

mportant; if item 27 is marked other than "natural", or items 23a or 28a-f show ny injury or other traumatic event, the M-di-al Examiner must be notified at one. Director Funeral Be Completed by

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland epartment of Health and Mental Hygiene. mportant: If Item 27 Is marked other than ပ Physician /Medical Examiner Examiner The law requires that the death certificate be executed the attending physician Physician/Medical After this certificate has been signed by the attendin funeral director, page 2 should be detached for use Completed by To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be Certification: To

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name	Hump]								April	Day 5	20	Year 07		:45p
4a. Facility Name (If			ımber)		4b. City,	Town, or	Location	of Death	115111			of Death		• 10 [
		pin Lane			М	idd.	le R	iveı	3		Bal	timo	ore	
5. Social Security No unknown		6. Sex 1 34 M 2 ☐ F	7. Age (<i>ln yr</i>	-	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da OCt . 1	th ay, Ye <i>ar)</i> 3 , 19	50	Coun	lace (Stai try) ana	te or Forei
Usual Residence of							,							
10a. State MD	10b. County Bal	timore	10c. (City, Town or Midd	lle Ri	ver						1		e City Limi es 2 🔼 N
10e. Street and Nun		pin Lane)		10f. Zip		1220				en of V uya	hat Coun	try?	
11. Marital Status 1		ried Armed F	2 ⊠ No iive	U.S.	13. Was Dece If Yes, spe 1 ☐ Yes	cify Cuba	ispanic Or an, Mexica Specify	n, Puerto	ecify Yes or No Rican, etc.)		Blac	e - Americ k, White, : Bla	etc.	1
(Spec		nt's Education est grade completed College) (1-4or 5+)	- (G	ecedent's Usu Give kind of wo fe. DO NOT u	al Occup ork done d se retired	ation during mos f)	st of work	ing	16b. Kir	rd of Bu	siness/Ind	dustry	
12tl				Cr.	ef		40.11		/F"	1				
17. Father's Name (First, Middle rt Hi								e (First, Middle nne Ph			ne)		
19a. Informant's Na Dionna I			er-in-		_				al Route Numb ane Ba	-				20
20a. Method of Disp 1 Burial 2 4 Donation	Cremation	3 □Removal fron		cemetery .	isposition (Na crematory or c W Cre	other plac	ory		Date 3 / 0 7			City or To	· ·	i
21. Signature of Fu	neral Service	Licensee	Og		22. Name a			. 3(00 Mac	_				MD 21
23a. Part1. Enter to shoot, or hea Immediate Cause (or complications that t only one cause on							or respiratory	arrest,			Onset a	Between nd Death
disease or condition resulting in death) Sequentially list configure in the configure in the cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, nmediate rlying injury	b. Hy Due to	o (or as a cons	EAS(V)	E CAK	MY0 2010	PATO VASC	uls	r Di	SEAS	€		1 ye	ear_
IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	1 ☐ Live	utcome pf pre birth 2□F gnant at time c nown	etal death	3 ⊟Ectopic p 5 ⊟ Other (s		/			2		te of delive	ery Day	Year
	ficant condit	ions contributing to	~			cause giv	en in Part	l.		tobacco u	se cont	ribute to ti		of death?
	-17166	// _/0".	<u></u>						24a. Wa		24b.	Were auto	psy findir	ngs availat

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

29b. Signature and title of certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

DO635706

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

BALTIMORE, MD

State Registrar



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Jean Elizabeth Housman 04 11:39 MM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death Examiner Baltimore Franklin Square Hospital Rasadale Center 8. Date of Birth (Month, Day, Year) Oct. 13, 1920 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) PA PA 1 □ M 2 □ NF 86 168-14-6588 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Middle River Baltimore 1 ☐ Yes 2 ☐ No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 23 Right Wing Drive 21220 Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home HOmemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hannah Wolfgang William Fetterolf ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23 Right Wing Drive Balto. MD 21220 19a. Informant's Name/Relationship (Type. Print) Donna Coldwell /daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 4/12/07 Baltimroe MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Funeral Service License Connelly Funeral HOme of Essex 21221 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A/Zheimers Due to (or as a consequence of neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner LOPD Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

The law requires that the death certificate be executed burial-tran attending physician for use as the burial Division or Vital Records, P.O. Box 68760 signed by to certificate or Attending Physician: After this within 24 hours after death To the Funeral Director: à

Funeral

Director

d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It hand Mental Hyglene. It is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

OUSMAN

Pages 1 and 2 should be 1 nent of Health and Mental

Department of Health a Important: If item 27 Is any Injury or other traconce.

Physician /Medical

Examiner

and

State Registrar

Medical

29b. Signature and title of certifier

29a. Certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

H0060805

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore MARYland 21237 9000 Franklin Square DR DR Anita NAIK

31. Date filed (Month, Day, Year) APR 1 3 200

32. Registrar's Signature

and manner stated.

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/Medi Examii		4a. Facility Name (umber)			4b. City, Town, or	r Location of Death		4c. County				_
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or A ter direct	Certification:	4 ☐ Homicide	determi	nod Zoe. Flag	ce of injury ding, etc.	y - At home (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tov		ber or Rura	l Route N	lumber,	
spital ours aneral	1	29a. Certifier	1 Certifyin	g Physician: To th	ne best of	my knowle	edge, deat	h occurred at the tir	me, date and place	, and due to the	cause(s) and m	anner as st	tated.		+
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only one)	2 ☐ Medical I	Examiner: On the and ma	basis of e inner state	examination ed.	n and/or in	vestigation, in my o	opinion, death occu	rred at the time,	date and place,	and due to	the caus	se(s)	
Vithi To th	Ž	29b. Signature and	title of certifier	7 . 1		21	΄ λ	29c. Licens			29d. Date signe	ed (Month,	Day, Year	r)	
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3		30. Name and add	ress of person	who completed car	use of dea	ath (Item 23	3a) (Type,				l DAI	Tille	or	21229	,
St.	ate	31. Date filed (Mor	nth, Day, Year)	38	Registrar	's Signatur	e #		11110 1	W II N	DAL	1 1 PC	11C,	XIX S	-
Regist	rar	A	IPR 13	2007	Jaka .	15.	1								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 09 **Physician** 2007 04 9:05p Harvey Sr. Arthur James /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Northwest Hospital Year) 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 07 30 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. X□ M 2□ F Yrs. 72 MD 213-30-5902 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Me Ireal Examiner must be notifiled at ty⊡Yes 2 □ No Baltimore Director MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U . S . A .

14. Race - American Indian, 21207 6406 Laurel Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐XNo 3altimore, Maryland 21215-0036 Specity. Specify: Black ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7/ th and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) General Contractor Home Improvement 12th grade lyrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Green Ernest Harvey ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jemit. Pages 1 and 2.
Department of Health an.
Important: If Item 27 is m.
any injury or other Dorothy G. Harvey-Wife 6406 Laurel Drive, Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 4/11/07 Randallstown, MD 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee Ave, Baltimore, Md 21215 4300 Wabash 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinitely access. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death curtificate be executed burial-trai Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LYMPHATIC LEUKEMIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No MELLINS, 24a. Was an DIABETUS was autopsy performed? certificate has b 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) Injury Natural 1 ∏Yes 2 ∏No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Funeral D etely filled in 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



Registrar

054288

Nextfirest Highital Center

			1- For Amend #19a Per Inf Coo 4/18/07 JH C	partment of Health and Mental Hygiene Pertificate of Death
	Physic		1. Decedent's Name (First, Middle, Last) 6REGORY H/LL	2. Date of Death Month Day Year 3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
1	LXaiiiii	ıcı	3540 Chesterfield Avenue	Baltimore NA
	Funeral Director		5. Social Security Number 6. Sex, 7. Age (In yrs. last birtha	Months Days Hours Min (Month Day Year) Country
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location 10d. Inside City Limits
	ith the Marylan or 28a-f show	ctor	MD NA Baltir	nore 157 Yes 2□No
	or 28	Dire	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	s 23a	rai	3540 Chesterfield Avenue	21213 USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avant. It a Madical Examiner trust be retilled at 000.8.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Syes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2X No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black
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ary	should and Men s marke	-		ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and 2 lealth a m 27 is		Erica Dickerson - Daughter 354	O Chesterfield Avenue Balto, MD 21213
Baltimore,	Pages 1 nent of H int: If itau		20a. Method of Disposition 20b. Place of Disposition 3 Demoval from State 20cremation 3 Demoval from State	sposition (Name of Date 20c. Location - City or Town, State rematory or other place)
Itim	permit. Pag Department Important: I any injury c		'4 □ Donation 5 □ Other (Specify) □ Garris C 21. Signature of Funeral Service Licensee	on Forest 4-17-2007 Owings Mills, MD 22. Name and Address of Facility March F/H East
Ba	permit. Departr Imports any injt		Draft Meller	1101 E. North Avenue Balto, MD 21202
П			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	
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Box (eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
o.	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		3□Ectopic pregnancy 5□Other (specify) Month Day Year
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n 0	ng Ph fter th ineral		27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day Year) 1 Natural 28b. Time (Month, Day Year)	of 28c. Injury at 28d. D scribe how injury occurred
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Div	spital or Attending Pours after death. Naral Director: After tilled in by the funera	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
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	To the Hos within 24 h To tha Fur completely	ledical	and manner stated.	investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
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ا	1		30. Name and address of person who completed cause of death (Item 23a) (Type	a Print Johns Hopkins Pavider PACE
3	9		4940 Easton Avenue, Be	1/5 m ne, MD 21224
	Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	esti
	Registr	ar	APR 1 3 2007 Jahren A. A.	70 P.E.

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month -**Physician** Apri 2007 PM -OUISe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) 2327 Charles Examiner Futurelare 57 111more If Under 24 Hrs. If Under 1 Year Months Days Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Hours 1□M 2∏F 91 216-24-2148 Usual Residence of Decedent Director 15 MD Pages 1 and 2 should be filed within 72 hours efter death with the Marylend 10a. State 10d. Inside City Limits 10c. City, Town or Location 10b. County other traumatic event, the Medical Examinar must be notified a X□Yes 2□No Director or 28a-f Baltimore MD NA 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number or items 23s / Funeral U.S.A. 2408 Monticello Road 21216 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 12 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: Be Completed by Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Claims Examiner 12th grade 4yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If Item 27 is marked or any injury or other traumatic eve 2 Geneva Lyles Thomas H. Kerr Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21216 Delores P. Kerr-Sister-In-Law 2408 Monticello Road, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 4/14/07 Arbutus, Md 22. Name and Address of Fecility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 28a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death hysician Immediate Cause (Final disease or condition resulting in death) /Medical ATIC CAVEINUMA Examiner Physician/Medical Examiner ettending physicien end I for use es the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed this certificate has been 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? To the Hospital or Attending Ph within 24 hours after deeth. To the Funerel Director: After th completely filled in by the funeral 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1-DiNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) tizerifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier mo 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) is Street Baltimore UI north CHAV m

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Mohth, Day, Year)

APR 1

3 2007 gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 1210 AM April ASHER HONICK 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/16/2003 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Social Security Number **Funeral** 3 214-67-3630 1 X M 2 □ F **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD N/A BALTIMORE 1X Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Department of Health and Mental Hygiene. Important: If Items 23a or Important: If Item 27 is marked other than "natural" or items 23a or any injury or other traumatic event, the Medical Examiner must be a one. Funeral <u>3805 LABYRINTH ROAD</u> U.S.A. Was Decedent Ever in U.S Armed Forces? 14. Race Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ▼ No If Yes, Give X Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) N/A NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EISENBERGER **JEFFREY** HONICK BERNICE ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 LABYRINTH ROAD - BALTIMORE, MD 21215 JEFFREY HONICK / FATHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State SHOMREÍ MISHMERES 04/08/2007 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS.. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dehydration 12 hors /Medical Due to (or as a consequence of): **Examiner** multisystem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine rBomy attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performe 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Hinpatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 [Lectlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, within 24 hours a

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D State Registrar

DHMH 17 Rev 1/2001

Haron

31. Date filed (Month, Day, Year)

SINAL Luckerbers MD HOSPITAL 32. Registrar's Signature

MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

2401 West Belvedere Avenue Bultimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** JOHN SON JELAH 2007 Hbrit /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MOPKINS HUSPITAL Mok If Under Hours Security Number 8. Date of Birth (Month, Day, Sept. 20 B. Birthplace (State or Foreign Gountry) 7. Age (In yrs. last birthday) **Funeral** Months Min 1□M 21 F 216-34-615 Usual Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 238 or 288-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director MOR 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Ve 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🗖 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) Balto. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Kusse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot Bunal 2 □Cremation 3 □Removal from State 200 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final iss ent yerr. **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the as esn If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown signed by 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ þe 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes this funeral Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natura. 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE HMAHD street Hork 600 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2058PM **Physician** ADRI 10 2007 Johnson Anna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ba Himare If Under 1 Year | If Under 24 His Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 ■ M 2 💢 F 86 Director 219-20-8054 04 29 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1

Yes 2 □ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be notified Director Baltimore NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 3809 Penhurst Ave Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 🎉 No Specify: 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry
St. Marks Baptist 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Pastor 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blanche Neal Albert Cohens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) daughter Naomi Jackson-Haskins 3809 Penhurst Ave, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge 4/17/07 Pikesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuscial Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Septic Shock.

Due to (or as a consequence of): Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Electricity Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) P.0 ate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform endomethal 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🔲 Yes 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APKI 10, 2007 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) MCHmm 31. Date files (Month, Day, State Registrar

	-	For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of Heriticate of L		, ,	ene . No. 20 (07	1778
Physiciar /Medica	n al -	Decedent's Name (First, Middle, Mary	L.		Jackson		2. Date of Death Month O4	08 2	Year 007 1	Time of Death 1:16a ^M
Examine		4a. Facility Name (If not institution, 1981)	on Ave ag	ot 316		ltimore			I/A	
Funeral Director		5. Social Security Number 217–20–5048 Usual Residence of Decedent	. Sex 7. A 1 □ M 2 X □ F	Age (In yrs. last birthday 84 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 05 21	^(ear) 22	9. Birthplace Country)	(State or Foreign
a-f show		10a. State 10b. County MD NA		10c. City, Town or L						side City Limits
23a or 28 ust be no	Funeral Director	10e. Street and Number 1700 Edmondso			10f. Zip Code 212				S.A.	
xan 3	2	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 【XDivorced	12. Was Deceder Armed Forces 1	No	Was Decedent of His If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American In , White, etc. Blac	
ene. than "natur he Medical I	Completed	15. Decedent's (Specify only highest	grade completed) College (1-4o	(Give	edent's Usual Occupa e kind of work done d DO NOT use retired, Teacher	ation furing most of worki)	ng E	Bb. Kind of Bus Baltim System		
ked other ic event, tl	Re	12th grade 17. Father's Name (First, Middle, La Alexander Jone	,			18. Mother's Name	(First, Middle, Ma	-	·)	-
n 27 is mark er traumati		19a. Informant's Name/Relationship Warren Jackso	(Type, Print)	1520	ing Address (Street a	and Number or Rura	Street	, Balt	.o, Md	21216
Department of Health a Important: If Item 27 is any injury or other trauonce.		20a. Method of Disposition 1 [X] Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	ecify)	St.	osition (Name of ematory or other place Lukes 22. Name and Addres	4/13		eister		
Depa Impo any ir		21. Signature of Funeral Service Li 23. Fart1. Inter the disease, or c shock, or heart failure. List or	March		March F/ 4300 Wab	H West ash Ave				.1215
Assician and the burial-transit transit al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Hu	s a consequence of): as a consequence of): as a consequence of):	earl to	alme	- -		On Z	et and beath Leas Leas Leas	
attending phy for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of delivery th Day	Year
igne be d	2	Part II. Of her significant condition	s contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contri	bute to the ca	use of death?
ate has beer page 2 shou	Completed	10	3				24a. Was an autopsy perform	ed? de		indings available ion of cause of No
this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa			4 LI Nursing Ho	me 5 Residen	ce 6 □Othe		
within 24 hours after cleath. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification:	27. Manner of Death Natural 5 Pending investiga 2 Accident 3 Suicide 6 Could no determin	t be 28e. Place of	njury 28b. Time Injury injury - At home, farm, s etc. (Specify)	M 1□	Yes 2 □ No	28d. Describe how 28f. Location (Stre City or Town,	eet and Numbe		ute Number,
Funeral Di	edical Cer		Physician: To the be	st of my knowledge, dea			and due to the cau	use(s) and mar		
To the comple	Med	29b. Signature and title of dentitier	and manner	MO	29c. License	6522	290	d. Date signed	(Month, Day,	Year) 7
		30. Name and address of person w	Solo	non a	7000	marry L	aku	De 3	1/20	7.
State Registra		31. Date filed (Month, Day, Year) APR 1 3		trar's Signature	bark	7	_			

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

07-02677 John Jackson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner 1220 hrs April 8, 2007 Jackson John 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 601 Wyanoke Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Davs Min. Months Hours Director 68 Country) 1 X M 12-8-1938 S.C. 2 F 212-36-0435 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location any 1 Yes 2 No fshow MD NΑ Baltimore or items 23a or 28a-f sho must be notified at once filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 601 Wyanoke Avenue 21218 S Α Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Yes Black Yes 2 X No specify: 3 Widowed Divorced If Yes, Give Year Specify: Examiner "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NA Pages 1 and 2 should be filed within 72 tent of Health and Mental Hygiene. ant: If item 27 is marked other than ' or other traumatic event, the Medical MD 21215-0036 8th grade Disabled 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clinton Jackson Bessie Locklear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 Bessie M. Anderson-Sister 8440 Allenswood Road Randallstown, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4-14- 07 CATONSVILLE, MD Western Star Cem Donation 5 Other Specify 21. Signature of Veneral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Avenue Balto, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Exsanguination Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Erosion of femoral artery Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause Acute and chronic inflammation complicating previous femoral-(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): temoral bypass graft and transit Physician/Medical X UNPENDED cate has been signed by the attending physician page 2 should be detached for use as the burial A#232Ec,PII,27, per ME, g868, 6/1/2007 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Yea Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ģ Atherosclerotic cardiovascular disease Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 2 No 1 V Yes certificate 26.Place of Death (Check only one) of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 V Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 1 X Natural 1 Yes 2 Division Pending death. the Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City ρ 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 To the one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 9, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner rar's Signature 31. Date filed (Month, Day, Year, State

Registra

			For State Registrar	State of Mai	ryland	•	rtment			and Me			007		1 7	80
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	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28e-f show do other than "natural", or items 20a on 28e-f show event, the Medical Examinar must be notified at		30461 Manor Drive						218	53			USA			
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<u> </u>	ar de recto	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	ry - At hom (Specify)	e, farm, str	eet, factory,	office		2	8f. Location (City or To		Number or F	Rural Rout	te Numbe	r,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:05 P M April 2007 Evelyn R. Kist /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🕅 F Maryland June 10, 1925 81 Director 218-12-3537 Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10h. County items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No Harford Bel Air Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21014 1201 Marywood Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping House Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Kirtscher Agnes Mitzell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1201 Marywood Drive Bel Air, MD 21014 Donna Olszewski (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 04-13-2007 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W.Macphail Rd. Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death INFLAMATORY RESPONSE SYNDROMA Immediate Cause (Final disease or condition resulting in death) SYSTEMIC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of): Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Generalized LYMPHADENOPATHY. 1 Yes 2 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No PANCYTOPENIA 24a. Was an performe RENAL ACUTE 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

within 24 hours after death

To the Funeral Director:
completely filled in by the within 24 hours a To the Funeral I

> 20 State

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifier

30. Name and address of person who

Kevin

Registrar DHMH 17 Rev 1/2001

ORIGINAL

ND

32. Registrar's Signature

CYNCH

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

\$35012 April 10, 2007.

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imore, MD 21215-0036 Pages I and 2 should be filed within 7 nent of Health and Mental Hygiene iant: If item 27 is marked other than or other traumatic event, the Medica	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
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e, MD I and 2 sho Health and item 27 is		SANDRA STOCKTON (MOTHER) 4131 MAPLE RD. SUITLAND, MD. 20746 20a. Method of Disposition / Date 20c. Location - City or Town, State						
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Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other tr		4 Donation 5 Other Specify: / SUSQUEHANNA MEMORIAL 4-14-2007 YORK, PA.						
nit. artm		21. Signature of Funeral Service Livensee JONATHAN D. HIBNER Name and Address of Facility JOHN DANNER FUNERAL HOME						
Dep Der Injury		822-30 E. MARKET ST. YORK, PA 17403						
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To the to to to to the	Medical	and manner stated						
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7/		O.C.M.E. April 8, 2007						
102		30. Name and address of person who completed cause of death (Item 23a)						
1		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
S	tate	31. Date filed (Month, Day, Year)						
Regis		APR 1 3 2007 Alexander American America						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Apri vance 10 7: 45 AM 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner BALTIMORE UNIVERSITY SPECIALTY HUSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-21-1930 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 242-42-575 Usual Residence of Deceden 15€M 2□ F Yrs Director 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County if Health end Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other treumstic event, the Medical Examinal must be notified at 1 Yes 2 No Funeral Director Saltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 permit. Pages 1 and 2 should be filed within 72 hours effer death 1 Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" eny Injury or other traum. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□ Yes 2⊠No Specify: Specify: ģ 3 Widowed 4 Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life: PS NOT) se retired) 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) torter ian orc Maiden Sumame) 18. Mother's Name (First, Middle, 17. Nather's Neme (First, Middle, Last) Be ince earner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Prin 412 K Falls Bridge 20b. Place of Disposition (Name of metery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore MD roin 21. Signature Funeral Service I 23a. Part 1. Entertible disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical 10 MINNES annythamias Cardiac Examiner Due to (or as e consequence of) hoomL discuse Physician/Medicai Examiner there sclerchic or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Hypertension ue to (or as a consequence of): debetes melling 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. After this certificate hes been signed by the efuneral director, page 2 should be deteched 3 □ Probably 4 □ Unknown 1 ☐ Yee 2 ☐ No rend Jevilare on Hencellalysis δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ruscular disense Be Completed ganguene (4) 1 ☐ Yes 2 No 1 ☐ Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Certification: To 1☐ Yes To the Hospital or Attending Phys within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D30494 4-10-67 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) South charles street Baltimane mo x 1230 WSH 501 KDESAIM

State

Registrar

31. Date filed (Month, Day, Year) APR 1 3

2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health, and Mental Hygiene Per MF, C866, 04/12/07dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Lee, Jr. 2116 PM MARC 2007 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Samaritan Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) D2 10 1943 Birthplace (State or Foreign Country) Age (In vrs. last birthday **Funeral** 1 XM 2 ☐ F -.40.6088 MO Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at Baltimore 1 Yes 2 No MD Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Silverthome Road INSA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Black þ Specify: 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker Bethlehem 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kebecca 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ewsbury Road Abingdon MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, MD King Park Cemetery 03/24/07 4 ☐ Donation 5 ☐ Other (Specify) laughn C. Greene Funeral Sives 21. Signature of Funeral Service License 4905 York Road Barto. MD 21212 23a. Part1. Enter the shock, or heart disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Immediate Cause (Final Suldural Rem **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) $g \mathcal{I} d \mathcal{U}$ Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Inknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Divaturat 1 ☐ Yes 2 🙀 No Unknown Unknown Probable fall 2X Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Unknown Unknown 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RESODO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANDA WASEM GOODSAHARITANHOSPI TAL 5601 LOCH RAVEN BLVD 39 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) David Lvles April 2 ď 🗗 7 12:16 pM 4c. County of Death Anne Arundel a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Death Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 8 - 3 0 - 1 9 6 3 9. Birthplace (State or Foreign Country)
Wash. DC 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) Social Security Number 579-94-9374 43 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 XYes 2 No MD Anne Arundel Annapolis 10f. Zip Code 21401 10g. Citizen of What Country? 10e. Street and Number USA 1179 Frederick Douglas St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status 1 Never Married 2 Married Black 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Moivorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Security Officer Private 18. Mother's Name (First, Middle, Maiden Surname) Helen Eleanor Huc 7. Father's Name (First, Middle, Last)
Mack A. Lyles, Hudson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3719 Bangor St. SE Washington DC 20020 John Hudson/ Uncle 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Zion Cem. 4-14-07 Mt. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility onald Taylor II Funeral Hm 21. Signature of Funeral Service Licensee 108 W. North Ave. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23d. Date of delivery utcome pf pregnancy 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day gnant at time of death 5 ☐ Other (specify) nown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes eath Check onl one Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. em 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

burial-transit and physician s the burial attending ph ed by the a signed to been si cate has b page 2 s certificate the Hospital or Attending Physician:

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical within 24 hours after death.

To the Funeral Director: After this funeral Certification: completely filled in by the

y Stotelly inc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, o 1□Live 4□Pre 9□Unk
completed by injurial	Part II. Other significant conditions of	ontributing to
2000	25. Was case referred to medical examiner?	Hospital: 1
1110111	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Dat (Mo

ner significant condition	s contributing to death but r	ot resulting in the und	erlying caus	e given in Part I.
ase referred to medical				26. Place of D
ner? es 2 x No	Hospital: 1 Inpatient	2 ER/Outpatient	3∐ DOA	Other: 4 Nursing

te of Injury onth, Day Year) 28b. Time of 28c. Injury at Work? Injury

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

29c. License numbe

29d. Date signed (Month, Day, Year)

State Registrar

Medical

wav 31. Date filed (Month, Day, Year)

Louid, us 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #19a, per FH, g866, 4/23/07 TT Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APPIL 05:15 M SHUN CHENG 10 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOPKINS BALT MOIS

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Feb. 4, 1957 CITY BALTIMORE HOSPITAL JOHNS Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1**∑**M 2□ F Months Taiwan 462-67-8016 50 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 3986 View Top Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager ATEC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Chiu Yu Pan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3986 View Top Road Ellicott City, Maryland 21042

29d. Date signed (Month, Day, Year)

10

2007

APRIL

with the Maryland 28a-f show notified at ò must be ral", or items 23a Examiner must b death v Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, tonce.

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

ပ

Hsin Lee

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 13

DAMY RUHL, MEDICAL DOCTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Laney

19a. Informant's Name/Relationship (Type. Print)

(Sister)

Funeral

Director

Physician /Medical Examiner

Be Completed by Physician/Medical Examiner physician and s the burial-trans signed by the attendin I be detached for use Medical Certification: To To the Hospital or Attenwithin 24 hours after death completely filled in by

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

20a. Method of Disposition 1 ☐ Burial 2XICremation 3 ☐ Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State						
4 □ Donation 5 □ Other (Specify)	Metro Crematory	4-12-2007	Catonsville, MD						
21. Signature of Funeral Service Licensee	Witzke Funera 5555 Twin Kno	lity Homes, Inc 11s Road Co	iumbia, MD 21045						
23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not enter the mode of dying, such	as cardiac or respiratory	Interval Between						
Immediate Cause (Final disease or condition resulting in death) Bowe Table 1 Bowe Ta			Onset and Death 3 DAYS						
Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	b. Due to (or as a consequence of): Due to (or as a consequence of):								
Due to (or as a	a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year						
Part II. Other significant conditions contributing to death but	at not resulting in the underlying cause given in Pa	art I. 23e. Did	tobacco use contribute to the cause of death?						
		1	Yes 2 No 3 Probably 4 Nnknown						
		24a. Was auto perf 1∐ Yes							
25. Was case referred to medical examiner?		ace of Death (Check only	one)						
1 ☐ Yes 2 No Hospital: 1 Nnpatie		Nursing Home 5 ☐ Res	idence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injuit (Month, Day)			how injury occurred						
C Could not be	ury - At home, farm, street, factory, office c. (Specify)	At home, farm, street, factory, office 28f. Location (St. City or Town							
29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, death occurred at the time, date	and place, and due to the	200100(0) and manage of the d						
(Check only one) 2 Medical Examiner: On the basis of one)	examination and/or investigation, in my opinion,	death occurred at the time	, date and place, and due to the cause(s)						

DHMH 17 Rev 1/2001

State

Registrar

29c. License number

AMY RUHL, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 268.

RES-000

			1 - State Registrar	State o	f Marylar				leaith a Death	ind Me		giene Reg. No.	007	11787	
			1. Decedent's Name (First, Middle, Las	t)							2. Date of De		V	3. Time of Death	_
	Physici /Medic		Ruth Oliver Lawso	n							Month 03	30	Year 2007	12:20 a M	
	Examin		4a. Facility Name (If not institution, give		mber)		4b. Cit	, Town, o	r Location of	f Death		4c. 0	County of Death		
			Holy Cross Hospit				-		Spring				ontgome		_
	Funeral		5. Social Security Number 6. Security Number 1	x □M 2XF	7. Age (In yrs.	Ven	If Und Months	Days	If Under 2 Hours	Min.	Date of Bir (Month, Da	th ly, Year)	9. Birth	place (State or Foreign intry)	
	Director	}	578-20-0634 Usual Residence of Decedent		84	Yrs.					03-17-	1923	unkı	nown	_
	and and		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation			· · · · · · ·				10d. Inside City Limits	_
	f ehe	ō	MD Montgom	ery	Silv	er Spr	ing							1 ☐ Yes 2 No	
	the 28s	Director	10e. Street and Number			-	10f. Z	ip Code				10g. Citiz	en of What Cou	intry?	-
	3a or	Ī	901 Arcola Ave.				2	0902				USA			
	me 2	Funerai	11. Marital Status	12. Was Dec	edent Ever in U		Was Dec	edent of H	ispanic Orig	jin? (Spec	cify Yes or No		4. Race - Amer		-
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hydiene. Important: if term 27 is marked other than "natural", or iteme 23a or 28a-f show important: if term 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Gir Year or D	2000		if Yes, sp 1 ☐ Yes	4.0	specify:	, Puerto F	Rican, etc.)		Black, White Specify: Whi		
ğ	2 hou	Completed	15. Decedent's Ed	ucation		16a. Dece	dent's Us	ual Occup	ation			16b. Kin	d of Business/li	ndustry	-
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7	giene giene	МO	12	, , , , , , , , , , , , , , , , , , ,		Homem	aker					At H	lome		
g	e file at Hy oth vent,	Be	17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middle,	, Maiden S	Su <i>m</i> am <i>e)</i>		
<u>ā</u>	Venta Menta rrked	ToE	unknown						unkn	own					
a	and l		19a. Informant's Name/Relationship				-						Town, State, Zi	p Code)	
≥ .	end Seelth n 27		Ryan T. Sumner/gra	andson				and the second	. Fre		ck, MD	2170	1		
altimore,	of Ho of Hi of Her or oth		20a. Method of Disposition 1 Burial 2 Gremation 3	Removal from		Place of Dispo cemetery, crei	osition (N matory or	ame of other plac	:ө)	Da	ate	20c. Loc	ation - City or T	own, State	
Ē	Pag ment ant: ury		4 ☐ Donation 5 ☐ Other (Specify			esapea	ke C	remat	oryA	pr.	6, 200	7 Be1	tsville	, MD	
Bail	epart oport ny in		21. Signature of Funeral Service Licen	S00	mol3	20			ss of Facility					ing, MD	
_	205 a d)	2	R							st Av.2		
			23a. Part1. Enter the disease, or comp shock, or heart lailure. List only	olications that one cause on e	aused the deal ach line.	h. Do not ent	ter the mo	ide oi dyin	ig, such as o	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	aSeps:	is synd	rome								Onsor and Boats	
	/Medical Examiner		resulting in death)	_	(or as a consec	juence of):									
		<u></u>	Sequentially list conditions,	b	nonia (or as a consec	mence oj).									_
<u>-</u> کہ	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10	(07 40 4 0011000	1401100 017.									
	al-tra	xar	that initiated events resulting in death) Last	c. Due to	(or as a consec	juence oi):									-
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89	ifficat g phy as th														_
ŏ	n cert endin use	ician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregn		7catania					2:	3d. Date of deliv	very	
P.O. Box	The law requires that the death certificate has been signed by the attending loage 2 should be detached for use as	sicia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregr	oirth 2 ∏ Feta nant at time old		Other (oregnancy specify)					Month	Day Year	
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ב	w require been sig should b	ted	Clostridium Diffic							sore	10	Yes 2	No 3□Pro	babiy 4 □Unknown	
ပ္ပ	has be	Completed by	Comfort Care, hyper	tension	, cong	estive	hear	t fa	ilure		24a. Was autor	DSV	prior to c	opsy findings available ompletion of cause of	
<u> </u>		S									perfo	rmed? 2 No	death? 1 ☐ Yes	2□ No	
Ħ	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11=== t=1				104		of Death	(Check only o	опе)			_
5	Physi this c al dir	ို	1 ☐ Yes 2 No			ER/Outpatier	_		4 🗆 1901				□Other (Spec	ify)	
ב	ding F	i o	27. Manner ol Death 1 Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time o Injury		28c. Injun Work			8d. Describe	how injury	occurred		
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Division of Vital Records,	al or A after I Direct din by	Certification;	4 Homicide determined	buildi	ol Injury - At h ng, etc. (Speci	fy)	eet, lact	ry, onice		-	City or To	wn, State)	TVUITIDET OF ALL	ar noble volliber,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier Certifying Ph	ysician: To the	best of my kno	owledge, deat	h occurre	d at the tin	ne, date and	d place, a	nd due to the	cause(s)	and manner as	stated.	_
	the thin 24 the F	Aedi	one)	and man	ner stated.						_ at the time,				
	To To con	Σ	29b. Signature and title of certifier	6 100	100			9c. Licens				29d. Date	signed (Month	, Uay, Year)	
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	2		30. Name and address of a rson who o					41	m C	ina	MD 200	0.2			
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				artment of Health and Mental H rtificate of Death	ygiene Reg. No.	11788
	Physici /Medio Examin	cal	1. Decedent's Name (First, Middle, Last) Jerome L. Lee 4a. Facility Name (If not institution, give street and number)	2. Date of I Month Apr 4b. City, Town, or Location of Death	Death Day Year 6 2007 4c. County of Death Baltima	3. Time of Death 12:30 p M
	Funeral Director		5000 Conant Way Apt K 5. Social Security Number 6. Sex, 2 F 7. Age (In yrs. last birthday) 10 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. 8. Date of E Months Days Hours Min. (Months)		lace (State or Foreign try)
	death with the Maryland me 23a or 28a-f show crives be notified at	Director	10a. State 10b. County Baltime 10c. City, Town or Lo	lfimme		0d. Inside City Limits 1 Yes 2 □ No
	23a or 2	ai Dire	10e. Street and Number Conaut way	10f. Zip Code 2/206	10g. Citizen of What Coun	try?
2-0036	n 72 hours after death with the Marylan "natural", or Iteme 23a or 28a-f show idical Examinar must be notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	0.1	
7-01717	ed within 72 h ygiene. ner than "natu t, the Modical	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) 12th grade 3 years H	dent's Usual Occupation kind of work done during most of working DO NOT use retired) Ousekeeping	Johns Hop	•
aryiand	s 1 and 2 should be fill f Health and Mental H: Item 27 Is marked oth other treumatic even	To Be	Thomas Henry Singleton	ing Address (Sireet and Number or Rural Route Num	nirlev Lee	Code)
more, M	Pages 1 and 3 ment of Health ent: If Item 27 lury or other tr		20a. Method of Disposition 20b. Place of Disposition 10 Region 3 Page 20 Competer, creation 20 Competers, creati	- Workstein	o, Md 21211 20c. Location - City or To Lansdown,	
Dall	permit. Depertuimporte any Inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility March 1101 E. North Aver	r F/H East nue Balto, M	1D 21202
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	ter the mode of dying, such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
,00	be executed cien and purial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	n dem		1998 2005
O. Box ox	ath certific ttending p or use as i	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delive Month	ry Day Year
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VII I LEC	in: The law r ificete hes be or, page 2 sh	e Completed	25. Was case referred to medical	pei 1 Yes	topsy prior to condeath? 2 No 1 Yes	psy findings available inpletion of cause of 2 No
SIOII OI AI	To the Hospital or Attending Physician: The law requir within 24 hours atter death. To the Funeral Director, Affer this certificate has been si completely filled in y the funeral director, page 2 should	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury 2 Accident investigation		y one) sidence 6 □Other (Specify e how injury occurred	r)
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	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurred at the time	e, date and place, and due to	the cause(s)
	CO Twith		29b. Signature and title of certifier MD	29c. License number D 15414 Print) Belaio Rd Bal	29d. Date signed (Month, 1947)	Loo 7
4	4		me and address of person who completed cause of death (Item 23a) (Type, VWONG VU NGUYEN 633)	Belair Rd Bal	timne MOZ	1206
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2007	cells.		

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

P57722

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** М JORDAN 06 LOWE 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4b. City, 10wn, 5.

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Examiner SILVER MONTGOMERY 1ATIGSOH 22092 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F Yrs. MARYLAND Director none Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or iteme 23a or 28a-f ehow permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or iteme 23a or 28e-f ehow amy njury or other traumatic event, fra Medical Examinatinal be notified at once. 1 Yes 2 No SPRING Director SILVER ND MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 02 P & 20910 GRORGIA AUF USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LAKEISHA PARKER LOWE JAMES SIFO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CROSS HOSPITAL 1500 FOREST GLEN SILVER SPRING HA BD HOLY20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state 21. Signatur Vineral Service Sicensee Ronal Service Wade, Wirector State Anatomy Board 655 W. Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 24 WEEKS **Physician** a EXTREME PREMATURITY resulting in death) /Medical Due to (or as a consequence of): Examiner RSPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in it and on the cause). Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed 9 DAYS SEPSIS attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 DAYS Completed by Physician/Medical INTRAVENTRICULAR HEMORRHUAGE IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 210 No 200 No 1 Yes 1 🗌 Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 06 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR DAWN WALTON 1500 FOREST GLEN RD SILVER SPRING MO 20910 31. Date filed (Month, Day, Year)
APR 1 3 2007 Registrar's Signature

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 14:55 700 Benjamin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Butimore

Vaar | funder 24 Hrs. N/A Miresity of 1 5. Social Security Number of Maryland Medical 8. Date of Birth (Month, Day, May 27 Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F Days Hours Yrs. 215-28-3217 75 1931 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be accessed. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2Y No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7578 Beach Road 21122 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Policeman Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) В. George Mortimer Sr. Mable Babylon ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne B. Mortimer (spouse) 7578 Beach Road, MD_21122 Pasadena, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the chease, or compilibations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Abdomina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Schemic Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical Milomina aneur IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the at I be detached for 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Other: 1 Yes 2 No 2 ER/Outpatient 1 🔀 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital within 24 hours a To the Funeral E 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UMM Licens 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 13 2007 Registrar

DHMH 17 Rev 1/2001

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** 10, MURPHY 2007 12:55 PM **HELENA** April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Catonsville
If Under 24 Hrs. 8. Date Baltimore St. Joseph Nursing Home If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗓 F Yrs Director 215-07-5023 20, Maryland Usuel Residence of Decedent the Maryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tam 27 is marked other than "naturel", or items 23s or 25s-f show other traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Woodstock 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours effer death with it Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "naturel", or items 23e propress. 3024 Hernwood Road 21163 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 M Never Married 2 ☐ Married White 1 ☐ Yes 2 ☑ No Specify Specify ٥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Murphy Sarah Sweet 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard D. Gover Nephew 3024 Hernwood Road; Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Gardens 4/14/07 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. MO1290 1630 Edmondson Avenue; Catonsville, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Aspirato hours Examiner Due to (or es e consequence of) Physician/Medical Examiner ete hes been signed by the ettending physician and page 2 should be deteched for use as the bunal-transit or Attanding Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, moti Due to (or as a consequence of): resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Ostcoaetheile ٥ 24b. Were autopsy findings 24a. Wes an autopsy Completed available prior to completion of cause of death? performed? 1 □ Yes 2 No certificete r: After this certifice e funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Certification: To 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred s efter dea... al Director: After to the fe 10 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. edical 29a. Certifier within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 2/0 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

Trootin

31. Date filed (Month, Dey, Year)

1 aca

32 Registrer's Signature

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ford

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 11 Year 2007 Ethel Garner Mingus 3:40 p M 04

Baltimore, Maryland 21215-0036

1 - For State Registrar

Division or Vital Records, P.O. Box 68760%

Physicia /Medic		Ethel Garner Mi	ngus					Mainth 04	Day 11	Year 2007	3:40 p M
Examin		4a. Facility Name (If not institution Casey House	n, give street and n	r Location of Death Le	1	4c. County					
Funeral Director		5. Social Security Number 577–16–6611	6. Sex 1 M 2 F	7. Age (In yrs. 85		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Count	ace (State or Foreign ry) ington, DC
	or	Usual Residence of Decedent 10a. State 10b. County MD Mont			y, Town or Lo						od. Inside City Limits
3a or 28a-f	al Director	10e. Street and Number 9603 Watts Bran	nch Dr.	Roc	.KVIIIE	10f. Zip Code 20850			10g. Citizen of V	What Coun	
rs atter deatt I", or Items 2 xaminer mu	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar **Widowed 4 □ Divorced	ried Armed F			Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Blad	ce - America ck, White, e y: whi	etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	Completed	15. Deceder	nt's Education est grade completed	f) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Teller	oation during most of wor d)	rking	16b. Kind of B		ustry
uld be filed v Mental Hygie irked other i itic event, tt	To Be Co	17. Father's Name (First, Middle James Francis				¥	18. Mother's Nan	_ `		ne)	
I and 2 sno Health and P Im 27 is ma Ther trauma	•	19a. Informant's Name/Relations Sandra Garner/			9603	Watts Brustion (Name of				20850	
nt. Pages ' artment of F ortant: If ite Injury or ot		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3	Specify)	m State Che	esapeak	natory or other pla	ory 4-1:	3-2007	Beltsvi	11e,	MD
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Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Deme	entia o (or as a consec							
eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consec	quence of):						
9 9	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live 4 ☐ Pre	outcome pf pregn e birth 2 Feta gnant at time of c	al death 3 [□Ectopic pregnanc □Other (specify) _	у		1	ate of delive	ry Day Year
The law requires that the de ate has been signed by the a page 2 should be detached	by	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did 1 □	1		e cause of death? ably 4 □Unknown
g S C	Completed							24a. Was auto perfo 1∐ Yes	an 24b. psy ormed? 2 12-N o	Were autoprior to condeath?	psy findings available npletion of cause of 2 ☐ No
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 [28a. Dat	☐ Inpatient 2 ☐ te of Injury onth, Day Year)	ER/Outpatier 28b. Time o	II 3 DOA	ner: 4 ☐ Nursing F	ath (Check only Home 5 ☐ Res 28d. Describe	- 1	her <i>(Specif</i>)	Hospice
l or Attendin after death. Director: Af I in by the fur	Certification:	3 Suicide 6 Could	not be 28e. Pla		ome, farm, sti		Yes 2 □ No	28f. Location (City or To	Street and Num. wn, State)	ber or Rura	l Route Number,
ne Hospita n 24 hours ne Funeral pletely fillec	Medical C		ing Physician: To t Il Examiner: On the and ma								
To the withing the confidence of the confidence	M	29b. Signature and title of certifi	mM	illes			se number 00580.	32	29d. Date signe		Day, Year) , 2007
To		30. Name and address of person Cynthia William	ns 6001 M	uncaster	Mil1	Rd. Rock	ville, MI	20855			
Sta Regist		31. Date filed (Month, Day, Year	2007	Registrar's Sign	ature	uli					

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p.

in 24 hours the Funeral Directory filled in br

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58303

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Afron J. Charles who 6701 No Charles St Charles mo

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Maryla			of Health a	nd Mental Hy	giene 007	11797
*\$			1. Decedent's Name (First, Mide	dle, Last)					2. Date of De	eath	3. Time of Death
	Physic /Medi		Dorothy Andr						Month		7 6:25 pm
	Exami	ner	4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, Tov	m, or Location of	Death	4c. County of Dea	ith
0	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	a last birthday)	If Under 1 Y				thplace (State or Foreign
6. 1.	Director		240-20-2969 Usual Residence of Decedent	1□M 2 ⊠ F	88	Yrs.	Months Da	ays Hours	Min. (Month, D. Nov. 7	ay, rear) C	th Carolina
	72 hours after death with the Maryland natural', or Iteme 23a or 28a-1 show dical Examiner must be notified at	_	10a. State 10b. Count	у	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	ours after death with the Marylan 'at', or Iteme 23a or 28a-1 ehow Examiner must by notified at	Director	Maryland Ha	rford		Bel Ai				· -	1 ☐ Yes 2 ☑ No
	with so	늡		5			10f. Zip Coo			10g. Citizen of What C	ountry?
	leath	Funeral	1200 Georgeto		cedent Ever in (15 13 1	210		in? (Specify Yes or N	USA 0- 14. Race - Am	oriogo lodigo
"	fter d	F	1 Never Married 2 Ma	Armed F	orces?	5.3.	f Yes, specify (Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	Black, Whi	
93	72 hours af natural', or	by	3X Widowed 4 □ Divorce	If Yes G	iive		∏Yes 2√2	No Specify:		Specify:	hite
20	72 ho	ted		nt's Education	1	16a. Deced	lent's Usual Oc	cupation		16b. Kind of Business	
21	E - E	nple	Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life. I	NOT use re	one during most o ntired)	of working		
21	illed with Hygiene other tha	Completed	, , ,	2	·	Pro	orietor	•		Real Esta	te
nd	d tal	Be	17. Father's Name (First, Middle	, Last)				18. Mother!	s Name (First, Middle	, Maiden Sumame)	
Za	should by	ပု	John (nmn) And						(nmn) Cho		
Maryland 21215-0036	2 0 0 0	1	19a. Informant's Name/Relation		. 1					er, City or Town, State,	
	1 an Heali em 2 ther		Carroll A. Hat 20a. Method of Disposition	TDC/20U-II		Place of Dispo			IVe, Bel A	ir, Marylan	
Baltimore,	0 0	1 57	1 SaBurial 2 ☐ Cremation		State	cemetery, cren	natory or other	place)		20c. Location - City or	
ij		1	4 Donation 5 Other (Gar	rdens o			4-11-07	Baltimore,	Maryland
Ba	Departr Departr Imports eny inje		16 m. 1	4/-					Hame, P.	A. don, Maryla	nd 21009
			23a. Part I. Enter the disease, of shock, or heart failure. Lis	or complications that tonly one cause on	caused the dea	th. Do not ente	er the mode of	dying, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	X	Low	mal	Da	1	14h		Onset and Death
1	/Medical Examiner		resulting in death)	Due to	or as a consec	uence of):	reme	1110	-WII		
	Lxammer		Sequentially list conditions,	t		Ŧ	ailu	ro to	o three	0	
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):					
	and and I-tran	хап	that initiated events resulting in death) Last	C. Due to	(or as a consec	Tuenos of):					
8760	cate be executed obysician and the burial-transit	a E		50010	(0) 43 4 00/1360	4001100 OI).					
687	death certificate be executed e attending physician and id for use as the burial-transi	dical		d.							
	leath certific attending p	/Me	IF FEMALE:	23c. If ves. or	tcome of pregn	ancv					
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live i	birth 2 Feta	al déath 3 🗌	Ectopic pregna Other (specify			23d. Date of de Month	very Day Year
o.	that the de ed by the detached	by Physician/Me	1 Yes 2 No 9 Unknown	9□ Unkn			Cirion (Specify	/			
U.	The law requires that the tte has been signed by th page 2 should be detache	y P	Part II. Other significant conditi	ons contributing to c	leath but not res	sulting in the un	derlying cause	given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Vital Records,	w require been sig should b								11	Yes 2 HNO 3 □ Pr	obably 4 []Uriknown
000	e law re has be- je 2 sho	Completed							24a. Was		itopsy findings available
Ě	The ate his	E O								rmed? death?	completion of cause of
ita	Physician: The la rthis certificate has ral director, page 2	Bec	25. Was case referred to medica examiner?	u L				26. Place of	1 ☐ Yes f Death (Check only of		21 110
	hysic his ce I dire	10	1 ☐ Yes 2 PNo			ER/Outpatient	3 DOA	Other		dence 6 □Other (Spe	cify)
D L	ng P	e .	27. Manner of Death 1 ☐Natural 5 ☐ Pendi	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Ir	njury at Nork?	28d. Describe	how injury occurred	
Sio	Attending or death. ector: After by the fune	cati	2 Accident investi	igation				☐Yes 2☐No			
Division of	l or At after d Direct I in by	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 28e. Place	e of Injury - At h ing, etc. <i>(Specii</i>	ome, farm, stre	et, factory, offi	се	28f. Location (S City or Tox	Street and Number or Ru vn, State)	ıral Route Number,
	Hospital	Ce	29a. Certifier 1/D Certifyin	na Physician To 4	host of e	audodes de d					
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical one)	Examiner. On the D	easis of examination of the state of the sta	ation and/or inv	estigation, in m	e time, date and p sy opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	to the cause(s)
	To the To the Comp	Me	29b. Signature and title of pertifie	1. 1	1		29c. Lice	ense number		29d. Date signed (Monta	h, Day, Year)
	1		()/\u00e4	mille	14	NO	D	19503		Annila	2007
1	1		30. Name and address of person	who completed caus	se of death (Iter	n 23a) (Type, E	ring	aL	4 M	1	1 I D
	1		Manuel	azati	/ DP	8	Law	STree	1/ Mac	-oleer,	blugan
	Sta Registra	te ar	31. Date filed (Month, Day, Year)	2007	legistrar's Signa	ature	E)			100	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend #20c, pe	State of MarFH, g866, 4/	aryland 13/07 T	I / Depa T <i>Cer</i>	rtment of F tificate of	lealth and Death	Mental Hy	giene Reg. No.2	07	1798
			Decedent's Name (First, Middle, L.)	.ast)					2. Date of De	eath		ne of Death
-	Physici - Medic	al	5 U S A N 4a. Facility Name (If not institution, g	MERME	FLS	TEIN		r Location of Deat	APRIL	Day 2 (-10 PM
7	Examir	er	NORTHWEST HOSP:					LSTOWN			IMORE	
- AT 4 1	Funeral Director				e (In yrs. la 63	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th av. Year)	Birthplace (St. Country)	ntate or Foreign
	70		Usual Residence of Decedent		40- 04	7			10,, 2,,			
	larylar show),	10a. State 10b. County		,	Town or Loc						de City Limits Yes 2, No
	the M 28a-f	rect	MD BAI 10e. Street and Number	_TIMORE	BAL	TIMORE	10f, Zip Code			10g. Citizen of W		X
	3a or	Ϊ́	3 SAMWOOD COUR	Г			21208	3			.S.A.	
	death	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13. V	Vas Decedent of H		Specify Yes or No		e - American India k, White, etc.	n,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 X Never Married 2 Married 3 Widowed 4 Divorced		No		☐ Yes 2 💢 No	Specify:	to rilican, etc.)	Specify.	MITT	E
5-0	72 hc "natur	etec	15. Decedent's (Specify only highest of	Education grade completed)	- 1	(Give i	ent's Usual Occup	during most of wo	rking	16b. Kind of Bu	siness/Industry	
121	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		OO NOT use retired ONE	3)		NONE		
	filed Hygi other ent, tl		17. Father's Name (First, Middle, La	st)		- 110	JIL	18. Mother's Nar	me (First, Middle	, Maiden Surnam		
<u>'lan</u>	uld be Aental rked o	To Be	JULIUS	ME	RMELS	TEIN		PAULINE	-	VOD	OROWITZ	
Maryland	2 should and N is ma	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Numb	er, City or Town,	State, Zip Code)	
_	l and lealth m 27		ANITA GELFAND /	SISTER			RTER DRIV	E-FRAMIN	NGHAM, M		O:t T Ot-	
altimore,	ages I nt of F : If ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		cei	metery, cren	natory or other plac			Baltimore	City or Town, Star	
를	nit. Paartme ortani injury		4 □ Donation 5 □ Other (Special Service Lice		DALI	17.00	HEBREW C			REISTER NSON & B		ID IC.
ñ	permit Depar Impor any ir once.		Michael	Thus,	<u> </u>	8	3900 REIS					
ì	37.47		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lir	the death.	Do nyt ente	er the mode of dyir	ng, such as cardia	c or respiratory a	ırrest,	Approx Interva	l Between
	Physician		Immediate Cause (Final disease or condition	//		rater	y fail	we!			Onset	and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	,					
		er	Securities list conditions if any, leading to immediate	b. Due to (or as	a conseque	ence of):	ry				_	
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6								
Ö,	e exec ian an urial-tr	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):						
38760,	icate be executed physician and s the burial-transit	dical	•	d					-			
~	± 0, 6		IF FEMALE:	23c. If yes, outcome	of pregnan	cv				, and Day	e of delivery	
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	death 3□	Ectopic pregnancy Other (specify)	1		Moi	e of delivery nth Day	Year
ري ح	s that med b e deta	by Ph	Part II. Other significant conditions	contributing to death be	ut not result	ing in the un	derlying cause giv	en in Part I.	23e. Did	tobacco use contr	ribute to the cause	e of death?
g	equire en sig ould b	ted k	Heaghin's ly	mphoma	Nur	rtal .	reland	wion	1 🗆	Yes 2 No	3 Probably	4 Junknown
ec	law r las be	Completed	ryportyres	dion so	hizo	phre	nia, t	ripolar	24a. Was	psy p	Were autopsy find prior to completion	
E E	r: The		discret	4					perfe 1□ Yes		death? I □ Yes 2 □ No	
₹ E	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	-4 000	D/O-tti	Oth	or.	ath (Check only			
ō	g Physer this eral di	٦: <u>٦</u>	27. Mayner of Death	1 Mnpatie	ry 2	R/Outpatient 28b. Time of	28c. Injur	4 LI Nursing F		how injury occurr		
<u>0</u>	ath. rr: Afte	ation	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigati		y Year)	Injury		K? Yes 2 □ No				
Division or Vital Records,	or Atte	Certification:	3 Suicide 6 Could not determine		ury - At hom c. (Specify)	ne, fa rm , stre	eet, factory, office		28f. Location (City or To	Street and Numbe wn, State)	er or Rural Route	Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is		29a. Certifier 1 Ty Certifying I	Physician: To the best of aminer: On the basis of	of my know	ledge, death	occurred at the tir	me, date and place	e, and due to the	cause(s) and ma	inner as stated.	
	the h thin 24 the F Tplete	Medical	29b. Signature and title of certifier	and manner sta	ated.		29c. Licens		and at the time			
	wii To	-	b b congony	Under. 1	1-1)		_	823		4 8	d (Month, Day, Ye	ar/
	H		30. Name and address of person wh			23a) (Type, F	Print)		0 1 : 1	-1-10-	14001111	
		to	31. Date filed (Month, Day, Year)	(HA)A 5	3.3 6 ar's Signatu	re P	10/25 (1	JUN RD	MALTI	NORE /	ハリケイタド	>
	Sta Registr		, , , , ,	2007	J. St.	April	TERS TO					
			F1.11 4 3 5	2 - Mr. 42-		-						

Registrar DHMH 17 Rev 1/2001 **Physician** /Medical **Examiner**

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anote.

MALAT, LAWRENCE

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Examine certificate be executed attending physician and for use as the burial-trar Physician/Medical Completed page 2 should this funeral Certification: After t

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

Division or Vital Records, P.O. Box 68760

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

1. Decedent's Name (First, Middle, Last) APRIL AWRENCE MALAT 11:31 PM 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER BURNIE GLEN ANNE ARUNDEL 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Days 1 → M 2 □ F 214-30-4643 73 Jan. 09 1934 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 159 Wileys Lane 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Policeman Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Malat Anthony Josephine Gac 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 Wileys Lane, Pasadena, MD 21122 Beatrice Diane Malat (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) JAUGA SILLARAYS 3 YEARS Due to (or as a consequence of): 20 YEARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 4 ☐ Homicide

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

29b. Signature and title of certifier Coliborne J. Gung 1000, MD 29c. License number D0065311A 29d. Date signed (Month, Day, Year) 12007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

GUICLERMO JOSE GIANERECO 301 HOSPITAL DRIVE, GUEN BURNIE, MD 20161 31. Date filed (Month, Day, Year) 32. Resistrar's Signature



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan	id / Depa		t of H	ealth a	and M		/	007	Miller of the Control
			Registrar 1. Decedent's Name (First, Middle, I	act)			uncau	e or L	Jeani		2. Date of Dea	eg. No.	C. C. 1	3. Time of Death
	Physici	an	0	MYERS							Month	Day	Year	2 450 M
	/Medi		4a. Facility Name (If not institution, g)		4b Cibe	Tourn	Location of	of Dogth	APRIL		2007 unty of Death	2111
	Examir	ner			-	nter	/	1			,			undel
			5. Social Security Number 6.			last birthday)	If Under		If Under					
	Funeral Director		256-52-4299	1 M 2 M F	72	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day July 19	9, 193	Coul	olace (State or Foreign ntry) DTgia
			Usual Residence of Decedent								oury r.	,, 1).	34 000	JIGIA
	yland yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mar a-f sl	ţo	MD Anne	Arundel	İ	Arn	o1d							1 ☐ Yes 2 No
	n the	irec	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cou	ntry?
	th wit	Funeral Director	305 College Parl	cway					2101	.2		U	SA	
	deal	ner	11. Marital Status	12. Was Decedent Armed Forces'	Ever in U	.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	city Yes or No- Rican, etc.)		Race - Americ	
9	or Ite	亞	1 Never Married 2 Married				1 ☐ Yes 2				rican, etc.)		Black, White,	ite
93	ural',	d by	3 ☐ Widowed 4 M Divorced	Year or Dates:			10 103 4	211110	эроспу.			Spi	ec <i>ify:</i> Wh	
5-	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Items 23a or 28a-f show event, the Medical Examination to Indiffed at	Completed	15. Decedent's (Specify only highest of			16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition <i>luring m</i> os	t of worki	ng	16b. Kind	of Business/In	dustry
12	within ene. then	m	Elementary/Secondary (0-12)	College (1-4or	5+)	l .								
2	filed v Hygie other t		12 17. Father's Name (First, Middle, La:	4		ed	itor/	Jour			(Fire & Adiabate		paper	
anc	d ital	Be	Harvey Addy	51/						te Sn	(First, Middle, i	vialueri Sur	name)	
Ž	should and Men marke	10	19a. Informant's Name/Relationship	(Time Print)		10h Mailie		/C4===1 =				O T-	01-1- 7	0.41
Maryland 21215-0036	2 a a		Lisa Peterson/d								<i>i Route Number</i> nold, M		.012	Code)
e,	is 1 and of Health item 27 other to		20a. Method of Disposition		20b. F	Place of Dispo			1				on - City or To	own State
Baltimore,	Pages nent of I int: If its iry or o		1 Burial 2 Cremation 3			emetery, crer			9)			200. Cocati	on ony or re	own, clate
Ħ	permit. Pag Department Important: I eny injury c		' 4 X Donation 5 ☐ Other (Spec				Name on	al A alabasa			6 E E	m 1.		
Ba	permit. Pages Department of Important: If i eny injury or once.		21. Signalure of Juneral Service Lic	Wade, Dir	ector						655 W.	Balt1	Lmore S	treet
		\vdash	23a. Part1. Enter the disease, or co	molications that cause	d the deat		1timo			2120]		not .		Approximate
			shock, or heart failure. List on	y one cause on each I	ine.	II. DO NOT BIR	er the mode	e or aying	, sucii as	Caldiac 0	i iespiiatory am	951 ,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Prec	imo	nid								
	Examiner		1	Due to (or as	a conseq	uence of):								
и		- L	Sequentially list conditions,	b. — Due to (or as	a consein	uence offi								
П	ted nsit	nin	Cause (Disease or injury	320 to got do	a conseq.	301100 31								
	xecu and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseq	uence of):							-	
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	ical		· .		•								
687	ficate phys s the	g		d					-					
×	eath certific attending p	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ıncy						23d	Date of delive	an/
Вох	atter for u	clar	in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic pre Other (spe					1	Month	Day Year
0	that the de led by the a detached	Physician/Med	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	9□ Unknown				- , , <u> </u>						
σ.	res that signed b be deta		Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tol	oacco use o	contribute to the	ne cause of death?
Records,	quires n sign	d by									1 □ Ye	s 2 N	o 3 🗆 Prob	ably 4 Unknown
00	w requir been si should	Completed									24a. Was a	n 24	4h Were auto	psy findings available
Re	The lavate has	mc									autops	y ned?	prior to co death?	mpletion of cause of
		C	25. Was case referred to medical						00 01	of Doorb		No	1 L Yes	28No
>		O B	examiner?	Hospital:	ent 2	ER/Outpatien	t 3 🗆 DO	, Othe			(Check only on ne 5 ☐ Reside		Other (Carrie	
	g Phys er this eral di	-	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of		Bc. Injury Work	at Nu		18d. Describe ho			y)
lon	for Att.	tlor	10⊠Natural 5 ☐ Pending 2 ☐ Accident investigate		y Year)	Injury	М		? ′es 2 🔲 I					
Division	Attending r death. sctor; After by the funer	ifica	3 ☐ Suicide 6 ☐ Could not	4 289. Place of an	ury - At ho	ome, farm, str	eet, factory	, office		2			umber or Rura	l Route Number,
Ó	afte s afte	Certification:	4 Homicide	building, et	ic. (Specif	Y)					City or Towr	i, State)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the to		29a. Certifier 1 Certifying F	hysician: To the best	of my kno	wledge, death	occurred a	at the time	e, date an	d place, a	nd due to the ca	ause(s) and	I manner as s	tated.
	the Ho nin 24 the Fu npletel	edical	(Check only 2 Medical Exp	miner: On the basis of and manner st	t examina ated.	tion and/or inv	estigation,	in my op	inion, deat	th occurre	ed at the time, da	ate and plac	ce, and due to	the cause(s)
	To the within 2 To the complet	Ě	29b. Signature and title of certifier				29c.	License	number				gned (Month,	
)			1 Anthoral				4	0005	6658	ig.		AP	RIL 8,	2007
			30. Name and address of person who	completed cause of o	death (Item	1 23a) (Type,	Print)				ANNAPO	-15 m	1 21	401
			TITUS ABRAHA	2007 33 Aegistr	nc 1to	SFITALK	T SE	2 VICE	= 5	7	Annapo:	edicio	e fort	way
	Sta		31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	A.	2000							7
	Registr	ar	APRIS	UUI JUSTELLA		. Pale	3.00							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Month Year **Physician** George Albert Naill М 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Town, or Location of Death Examiner TIMORE 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 21, 1926 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days **X** M 2 □ F Mary land 217-18-4722 81 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Middle River Maryland Baltimore 1 ☐ Yes 2€XNo Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 U.S.A. 203 Mulberry Lane 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. YSYes 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes XX No Specify: WWII Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Sinai Hospital 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Elizabeth Eyler Charles Naill 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Mulberry Lane, Baltimore, Maryland 21220 Ruth Naill (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Md. Veterans' Cem. 04/17/2007 Garrison Forest, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consec Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Certification: To 1 Yes 2 ER/Outpatient 1 Inpatient this Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person

Year,

Maryland 21215-

P.O. Box 68760,

Division or Vital Records,

ted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) ...

For State	State of Maryland				lental Hyg	giene nn 7	11802
Registrar		Certifica	ate of Deat	th	1	Reg. No.	11000
1. Decedent's Name (First, Middle, Last) HELEN M.NEDROW	1				2. Date of Dea	8ay 2009	3. Time of Death 1908 p M
4a. Facility Name (If not institution, give s	treet and number) + A	1 4b. C	ity, Town, or Location	on of Death	1	4c. County of Dea	th
220 22 7100	7. Age (In yrs. In 79	Yrs. If Ún Monif		der 24 Hrs. rs Min.	8. Date of Birt. July 2	9. Bin O earl 927 Mary	hplace (State or Foreign buntry) Land
Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Location					10d Jasida Cit. Linia
MD Balti		Parkvi	lle				10d. Inside City Limits 1 ☐ Yes 2 🟋No
10e. Street and Number 7102 Park Drive		10f.	Zip Code 21234			10g. Citizen of What Co USA	•
11. Marital Status	2. Was Decedent Ever in U.S		cedent of Hispanic	Origin? (Sp	ecify Yes or No-	14. Race - Ame	ncan Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:		pecify Cuban, Mexic		Rican, etc.)	Black, Whit	
15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's U	sual Occupation work done during m	nost of work	ana	16b. Kind of Business	Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Homem	use retired)	nost of work	ang .	At Home	9
17. Father's Name (First, Middle, Last) Frank. Smetor	1				e (First, Middle, Lukas	Maiden Surname)	
19a. Informant's Name/Relationship (Type Charles Nedrow-	· · · · · · · · · · · · · · · · · · ·	19b. Mailing Addre	ess (Street and Num ark Driv	nber or Rur. Ve-Pa	al Route Numbe	r, City or Town, State, 2 .e, Marylai	Zip Code) nd 21234
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	ace of Disposition (Ametery, crematory of Disposition Notes 1 and	r other place)_	4-13-	Date -07	20c. Location - City or Baltimore,	
21. Signature of Funeral Service License		Cemeter 22. Name EVANS	and Address of Fac FUNERAL	CHAPI	Till Dow	Harford Rokville.Mar	pad yland 21234
23a. Part1. Enter the disease, or complic	rations that caused the death		REMATION		TCEO		Approximate
shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequi	cordi	م ا	In	force	100	Interval Between Onset and Death
Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequi						
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						
L d.		51100 017.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No 9 □ Unknown	c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 ⊟Ectopic				23d. Date of deli Month	very Day Year
Part II. Other significant conditions cont	ributing to death but not resul	ling in the underlying	cause given in Par	rt I.	23e. Did to	bacco use contribute to	the cause of death?
Idispatric	Thron			PURA		es 2□No 3□Pr	
					24a. Was a autops perform	med? prior to death?	topsy findings available completion of cause of
25. Was case referred to medical examiner?				ace of Death	n (Check only on	n6)	
10 165 2500		R/Outpatient 3□ I		Nursing Ho	me 5 Reside	ence 6 Other (Spec	cify)
27. Manner of Death Natural 5 Pending a Recident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 [28d. Describe ho	ow injury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - AI hon building, etc. (Specify)	ne, farm, street, fack	ory, office		28f. Location (SI City or Town	treet and Number or Ru n, State)	ral Route Number,
29a. Certifier (Check only one) 1 Certifying Physical Examine	cian: To the best of my know er: On the basis of examination and manner stated.	ledge, death occurre on and/or investigation	ed at the lime, date on, in my opinion, de	and place, leath occurr	and due to the cared at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
29b. Signature and title of certifier		2	9c. License numbe			9d. Date signed (Monti	
1			4005	91	40	April 9	,2007
30. Name and address of person who com	npleted cause of death (Item :	23a) (Typa, Print).	Ravens	ivd J	Bultim	ore MD 2	21239

State

Physician /Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	er en		1 - For State Registrar	State of	Marylar		artmen rtificat			and M	lental H	ygien Reg. N	2 U l	de de la company	11803
	Physici	an	Decedent's Name (First, Middle, I	Last)							2. Date of I		ay	Year	3. Time of Death
	/Medi		Josephine		osa			Na	ylor		April	1		2007	1:46 P M
	Examir	ner	4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City,	Town, or	Location of	of Death	•	4	c. County	of Death	
	THE A	Mr.	Quail Run Assit					rry	Hall				Balt:	imore	
н	Funeral			. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of 8 (Month,	Day, Yea	r)	9. Birthp Coun	lace (State or Foreign try)
P _e c	Director		213-28-3163 Usual Residence of Decedent	-X		86 Yrs.					May	23 1	920	Peni	nsylvania
	land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation		· · · · · ·					1	0d. Inside City Limits
	Mary feb	ō	Maryland Baltim	ore	Pe	rry Ha	11								1 ☐ Yes 2 ☑ No
	179 1288	Director	10e. Street and Number			TLY III	10f. Zip	Code				10a C	itizen of	What Coun	11
	3a o		9904 Quail Run												.,,
	ms 2	Funerai	11. Marital Status	12. Was Decede	nt Ever in U	l.S. 13.		1234 dent of Hi		gin? (Spe	ecify Yes or ! Rican, etc.)	No-		S.A.	an Indian,
9	or Ite	Ē	1 Never Married 2 Married	Armed Force	es? ☑ No	1				, Puerto	Rican, etc.)			ck, White,	
03	72 hours after death with the Maryland naturel', or items 23a or 28a-1 ehow disal Ezamanar muni be moillied at	b	3X Widowed 4 ☐ Divorced	I ☐ Yes 2- If Yes, Give- Year or Date	s:		1 ☐ Yes	A No	Specify:				Specif	_{v:} Whit	-0
21215-0036	72 h	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usua	al Occupa	ation	of worki	na	16b.	Kind of B	usiness/Inc	
21	within ene. than "	npi	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of wor DO NOT us	se retired,)	or worn	···g				
	led w		12	NA.		Super	visor	in,						nem St	eel
and	be fi	Be	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Midd	le, Maide	n Suman	ne)	
3	J Ment J Ment narked natic e	To	Domenico		Be	nnici			Mar			_			iccione
Maryland	12 shou h and M 7 is mar traumat		19a. Informant's Name/Relationship								l Route Num				Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-1 show other traumatic event, the Medical Expirity in must be rediffied at	1	George Naylor (Cousin)	20h F	2960 Place of Dispo	York	way	Balti		Mar				- 0
Baltimore	Pages nent of int: if it		1 ⊠Burial 2 ☐ Cremation 3		1 ,	cemetery, crer	natory or o	ther place	9) ¦ A	April	l 17,	20C. I	_ocation -	City or To	wn, State
Ħ	permit. Pages Department of Important: if i eny Injury or once.		4 Donation 5 Other (Spec	•	Mou	nt Car	mel C	emet	ery	2	2007	Jer	mers	town,	Pa.
Bal	Depa Depa Impo		21. Signature of Funeral Service Lic	ensee	- 17	W 22	. Name an • Dab	d Addres YOWS	s of acility ki/Ch	, ojna	.cki Fu	ınera	al Ho	ome P.	Α.
700		-	ash a	(homa	rch.	1	005 D	unda	1k A37	e B	altimo	re	Mary	land	21224
*		· -	23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications mat causely one cause on each	sed the deat in line.	h. Do not ent	er the mod	e dynyg), such as o	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a CHA	PUIC	HES	RTI	12/	Luch					5	Ty
*	/Medical Examiner		rosaling in doaling	Due to (or	as a conseq		0.		m.		+				
**	%	<u></u>	Sequentially list conditions,	b. Due to /er	as a conseq	TIL	FARE	27	Phi	4/-	wriA			4	yr .
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (01	as a conseq	1	RI	2 . 4/	1.0	~ 6	Fran			1	
•	al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or	as a conseq	Lewice of):	· V /2	UHL	- 101	4	1-1 pm	7		L	Th
8760,	cate be executed physician and the burial-transit					,					/				
687	ficate p phy: s the	Physician/Medical		d											
Box	that the death certific ed by the attending p detached for use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregna	incy							23d Da	te of deliver	
m	death a atte	cial	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant			Ectopic pre Other (spe								Day Year
P. 0	the oy the	nys	9 Unknown	9□ Unknowr				<i>,,</i> —							
ر. ح	The law requires that the death certific tale has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did	tobacco	use cont	ribute to the	e cause of death?
ğ	n sig	D D									1 🗆	Yes 2	≥□No	3 Proba	ibly 4 🖟 Unknown
00	s been si	jet									24a. Wa	s an	24h 1	Were auton	sy findings available
æ	The la	Completed									aut	opsy formed?		prior to com death?	pletion of cause of
ā	an: J		25. Was case referred to medical						26 Place	of Dooth	1 Yes		0	I □ Yes	2.2 No
>	ysici s cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	itient 2	ER/Outpatien	t 3 🗆 DO	Othe			<i>(Check only</i> ne 5 ☐ Re:		c 🗆 🗆	/0 4	1
0	Attending Physician: r death. sector: After this certifica by the funeral director.		27. Manner of Death	28a. Date of I	njury	28b. Time of		Bc. Injury Work			8d. Describe				/
<u>o</u>	ath. r: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati		Jay Year)	Injury	М		? es 2□N	10					
	f or Attending I after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 25e. Place of	Injury - At ho	ome, farm, stre	et, factory,	, office		2				er or Rural	Route Number,
	s after s after al Dire	Ser	4 - Hornolds	building,	etc. (Specify	Y)					City or 1	own, Stat	Θ)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying F	hysician: To the be	st of my kno	wledge, death	occurred a	at the time	e, date and	place, a	nd due to the	e cause(s	s) and ma	inner as sta	ited.
	he H in 24 he Fi plete	edicai	one)	miner: On the basis and manner	ot examina stated.	tion and/or inv	estigation,	in my opi	inion, death	h occurre	d at the time	, date an	d place, a	and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier					License						d (Month, D	
				N.	11			PI	422	2/		1	7.11	07	7
1	1		30. Name and address of person who	completed cause o	f death (Item	23a) (Type, I	Print)								
2			Tarique Firozvi M	.D. 223 E	aster	Blvd.	<u>Bal</u> t	imor	e, Ma	aryla	and 21	221			
10 m	Sta	te	31. Date filed (Month, Day, Year) APR 1 3 200	32. Regi	strar's Signa	ture									
A. 18	Registra	ar	W 17 5 700	falses.	15º	Good	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland	-	artment of H				giene Reg. No. 2	007	11804
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	A	Nu	ie j				2. Date of Dea Month	Wil Day 10		3. Time of Death 7 0216 A M
<i>Y</i>	Examin Funeral Director	er	059-26-7799	General ,	Hu Spil (In yls. la 74	st birthday) Yrs.	4b. City, Town, or If Under 1 Year Months Days	U/U	24 Hrs.	8. Date of Birth (Month, Day Sept. 2	/ Year)	Cou	
	Aaryland F ehow	ŏ	Usual Residence of Decedent 10a. State 10b. County Maryland Howard		10c. City,	Town or Lo							10d. Inside City Limits 1 Yes 2 XNo
	with the h a or 28a-i Lbe notifi	Director	10e. Street and Number 10333 Nightmist				10f. Zip Code	1044			10g. Citizen o		untry?
920	ges 1 and 2 should be liled within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	by Funerai		12. Was Decedent E Armed Forces? 1 → Yes 2 → N If Yes, Give Year or Dates:		· ·	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 X No			ecify Yes or No- Rican, etc.)		lace - Amer	ican Indian, , etc.
21215-0036	d within 72 ho piene. r than "natur Ine Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5-	+)	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	du <i>ring</i> mos)	it of worki	ng	16b. Kind of N.S.		ndustry
Maryland 2	ould be filed when the filed wents his proper the filed water	To Be C	17. Father's Name (First, Middle, Last) Jose Nunez						er's Name Unkn	(First, Middle,	Maiden Sum	ame)	
	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship (Ty Scott Nunez (SON			12738	ng Address (Street a		ed O	cean Ci	ty, MD	2184	2
Baltimore,	Pages 1 ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		ArT	ingtoi etery	sition (Name of nate y orother plac nationa	12'		-2007	20c. Locatio Arling		rown, State Virginia
Balt	permit. Pag Department Important: t any injury o		21. Signature of Funeral Service Licens	man	0105		Name and Address Witzke F 5555 Twi	n Knc	lls	Road C	olumbi	a, MD	
760,	Physician /Medical Examiner properties prize pri	icai Examiner	23a. Part1. Enter the disease, or complished, or heartfailure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a conseque	ence of):	sion.						Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificat site has been signed by the ettending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3[Ectopic pregnancy					Date of deli	very Day Year
α_	w requires that the de been signed by the e should be detached f	þ	Part II. Other significant conditions con	ntributing to death bu	it not resul	lting in the u	nderlying cause give	en in Part I	l.		obacco use co ′es 2□No		the cause of death?
Il Records,	: The law requ cete has been , page 2 shoul	Completed								24a. Was autop perfo 1 🗆 Yes	rmed?	prior to c death?	topsy findings available completion of cause of
	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 ☐ Inpatie	nt 2.158°E	R/Outpatier	nt 3 DOA Oth	250		n <i>(Ch</i> eck only o		Other (Spec	city)
Division of Vital	Attending Physician: The Indeath. In death. In		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y Year)	28b. Time o Injury	Worl	yat k? Yes 2 □		28d. Describe h	now injury occ	urred	
Ŏ N	= 00	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	iry - At hor . (Specity)	ne, farm, sti	eet, factory, office			28f. Location (5 City or Tox	Street and Nu vn, State)	mber or Ru	ral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical		sician: To the best oner: On the basis of and manner sta	examinati	on and/or in	vestigation in my o	ninion dea	ath occurr	ed at the time	date and place	e and due	to the cause(s)
)	To with	2	29b. Signature and title of certifier	King	m	.0.	29c. Licens D 3 Print) Jan Lane	e number	26		29d. Date sig	/07	n, Day, Year)
	6		30. Name and address of person who co	mpleted cause of de	eath (Item	23a) (Type,	Print) Janlane	C	· lum	bra p	nary	land	
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 3 200	32. Registra	r's Signati	ure					7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 2-19AM 200 ianne 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) 1 M 2 F Min. Baltimore, ND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits shov notified at IM 1 ☐ Yes 2 No Funeral Director 510r 0 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or must be r Was Decedent Ever in U.S. Armed Forces?

1 Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. 11. Marital Status Black, White, etc. d other than "natural", or iter event, the Medical Examiner 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Whit Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Managemen 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be 10 ျှ nner MDI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 □Removal from State Highviow Men Coundars 13-01 tall Ston 22. Name and Address of Facility 3 A. Forest HILMOZICE 21. Signature of Funeral Service License MI 23a. Partf. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Fin disease or condition resulting in death) Physician /Medical Due to (ir as a consequence of) Examiner Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician at the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 sl perforn 2 No 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident atter death.

Director: / 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hin 24 hours att the Funeral Di mpletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number

within 24 the ٤

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, 1800

01 32. Registrar's Signature

Amend Items State of Maryland Pepartman, eddeath and Mental Hygiene 2007 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 0540 A M 1 XXX I G rebruar C IN 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Hay boy enter 8. Date of Birth (Month, Day, Year) Sep. 24, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 218 F 1911 Czechoslovakia 95 Director 088-09-7463 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23e or 28e-f show empiripury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 611 North Court 21090 **USA** by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 ☐ Divorced white white Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Baltazar Sadera Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Burke - Daughter 611 North Court Linthicum, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) Feb. 10, 07 Baltimore, MD Metro Crematory 21. Signature of Funeral Service Licensee Cremation Society of Maryland, Inc 299 Frederick Road Baltimore, MD 2 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Fractures of the Right Shoulder and Approximate Interval Between Onset and Death Fractures of the Right Shoulder and Immediate Cause (Final disease or condition resulting in death) **Physician** -cit at home Right Hip /Medical Due to (or as a consequence of): **Examiner** CENTRICATION APPROVED BY MEDICAL EXAMINER distocation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) sete hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes ZONO 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 SINGIUI al 5 Pending death. spital or Attandi lours after death. nerel Director: A investigation 02/07/2007 12:15 1 Yes 2 No Subject fell 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) MD 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 611 North Court, Linthicum To the Hospital or within 24 hours at To the Funerel D Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Heights
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOOD lanneru MO Harbur Hospital 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Lee-Anne Manney Handler Street Bultmare 300 M 31. Date filed (Month, Day, Year) APR 1 2 2007 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

07-02766

All Copies Are Legible. Mental Hygiene

07-02766	Please Type or Print in Black Indelible Ink. Ensure All C
Charles L. Parker	State of Maryland / Department of Health and Menta

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led)	Physicia ical Exami	an/	Decedent's Name (First, Middle)	_	Т			Sr .	2. Date of Deal Month April 11, 2		3. Time of 1905	
neal ⊸⊲	icai Exami		Charles 4a. Facility Name (if not institution	L .		Parker	City, Town,			4c. County of		
			Johns Hopkins Bayvie				Baltimore					
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	te Maryland or 28a-f show fied at once.	_ U L	10e. Street and Number	INOIC			10f. Zip Code		1	0g. Citizen of Wh	nat Country?	-
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	hours after death with the Maryland matural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.				in? (Specify Yes or No Puerto Rican, etc.)	- 14 Race White	- American Indian,	Black,
	or ite	핆	1 X Never Married 2 M	1 X Yes 2	No						White	
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6	0036 within 72 siene. ner than " Medical I	m du	12 years			Truck	Driver			Freig		
			17. Father's Name (First, Middle,						s Name (First, Middle, I)	
Š	21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	Charles Jasper 19a Informant's Name/Relations		1	9b. Mailing A	ddress (Str		erine Sadle: ber or Rural Route Num		n, State, Zip Code)	
	MD 7		Sharon Parker	wi	fe	1753 B	rookvi	ew Roa	ad, Dundalk	.Md. 21	222	i
-	tra item		20a. Method of Disposition 1 X Burial 2 Cremation	2 Pamoual from Str	20b. Place		on (Name of c		April 17,	20c. Location -	City or Town, State	
	Pages nent of ant: I		4 Donation 5 Other S		Oak :	Lawn C	emeter		2007	Dundall		
3	Baltimore, permit. Pages 1 at Department of He. Important: If ite	- 1	21. Signature of Funeral Service	1 11.		22. Nar	ne and Addre	ss of Facility Fune:	ral Home Of	Dundall	<,P.A.	
	, N	-1	23a. Part I. Enter the disease, or	complications that caused	ne death. Do	71	10 Sol	lers I	Point Road,	Dundall	Md 212	22 late Interval
	Physician /M di al		failure. List only some cause	on each line.							Between	Onset and eath
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	of Vit ing Physic After this	욘	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	nt 2 🗸 ER/	Outpatient Time of Inju		jury at Work		Residence 6 how injury occurr	Other:	• 1 •
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	To the Hos within 24 h To the Fur completely	Medical		miner:On the basis of exa and manner stated	mination and/o	r investigatio			curred at the time, date			or)
		2	29b Signature and title of certific	1 V				nse number		April 12, 20	ed <i>(Month, Day</i> , Ye 307	ur /
	T		30. Name and address of person	who completed chiese of	eath (Item 23a	1				, , , , , ,		
	0		Theodore M. King, Jr.				11 Penn S	Street, Ba	Itimore, MD 21201	1		
	S	tate	31. Date filed (Month, Day, Year)	AAA7 KEELOO	r's Signatu	A STATE			-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year William F. Purdy 0 2007 2:05 04 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery BrookeGrove Nursing & Rehab. Sandy Spring
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X**M 2□F 90 206-09-0677 New York 7-22-1916 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 13413 Rippling Brook Dr. 12. Was Decedent Ever in U.S. Amed Forces? 1 Deces 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Patent Attorney

18. Mother's Name (First, Middle, Maiden Surname)

ir than "natural", or Itema 23a or 28a-f ehow the Medical Examinar must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Director

Funeral

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Completed

MD

17. Father's Name (First, Middle, Last)

Funeral

Director

death with the Maryland

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle, M	aiden Sumame)	
To	William F. Purdy,	Sr.				Greta I	Ooane		
	19a. Informant's Name/Relationship (Type	e, Print)	19	b. Mailing Add	tress (Street	and Number or F	Rural Route Number,	City or Town, Stat	e, Zip Code)
	Carole Stevens/dau	hter	1	3413 R	ipplin	g Brook	Dr. Silve	r Spring	MD20906
	20a. Method of Disposition		20b. Place	of Disposition	(Name of			0c. Location - City	
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	21. Signature of Funeral Service Licensee	mol	358		e and Addre	•	Si em.Svc 933	lver Spr Gíst Av	
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the	e death. Do	not enter the	mode of dyin	g, such as cardia	ac or respiratory arre	st,	Approximate Interval Between
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<u>s</u>	in the past 12 months?	1 Live birth 2 [4 Pregnant at tim			oic pregnancy or (specify)			Month	Day Year
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by Physician/Medical Examiner	Part II. Other significant conditions contr	ibuting to death but n	ot resulting	in the underly	ing cause giv	an in Part I	23e Did tob	cco use contribut	e to the cause of death?
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Ë							perform	ed? death	1?
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2	27. Manner of Death	1 Inpatient	2 ER/C	Time of	J DOM	4 Janursing	Home 5 Resider		ipecify)
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cat	2 Accident investigation 3 Suicide 6 Could not be			M		Yes 2 □ No			
₹	4 Homicide determined	28e. Place of Injury building, etc. (- At home, : Specify)	arm, street, fa	ctory, office		28f. Location (Street) City or Town,		Rural Route Number,
Ö									
Medicai Certification;	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of m or: On the basis of ex and manner stated	amination a	ge, death occu nd/or investiga	rred at the tin ation, in my o	ne, date and place pinion, death occ	e, and due to the car curred at the time, da	use(s) and manner te and place, and	as stated. due to the cause(s)
ž	29b. Signature and title of certifier				29c. Licens	number	29	d. Date signed (M	onth, Day, Year)
	= JEHoure.	MD			D33	700	A	pril 12	2007
	30. Name and address of person who com	pleted cause of deat	h (Item 23a	(Type, Print)					
	154 N. ARTIZAN	ST. W	LLIA	MSPORT	· MD	7.17	13		

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State

Registrar

APR 1 3 2007

31. Date filed (Month, Day, Year)

SI.

32. Registrar's Signature

To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Director: After this certifica

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FOI	partment of Health and Me ertificate of Death		12007 11000
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. N	3. Time of Death
н	Physicia	an		ETTIS, SR		ay Year
Marie Contract	∜Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	9 2cc 7 / 4:05 M
	Examin	eı	Johns Hopkins Hospital	Baltimore	1	NA
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Yea.	r) 9. Birthplace (State or Foreign Country)
н	Director		219–38–2218		6-22-19	
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Maryl -f sho ied a	tor	MD NA Baltimo	re.		1 ☐Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	th wit 23a o 1st be	a D	1344 Kitmore Road	21239	U	S A
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric 	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by F	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
8	thour	edt	15 Decedent's Education 16a, Dec	cedent's Usual Occupation	16b.	Kind of Business/Industry
215	hin 72 3. In "na Medio	plet		ve kind of work done during most of working b. DO NOT use retired)	J	Johns Hopkins
21	d with	Completed	12th grade 4 years Pa	thology		Hospital
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (I	,	en Surname)
<u>}</u>	ould I Men narke	P	Otis Pettis	Gladys B		
Mai	d 2 sh th and 7 Is n traun		[3		MD 21239
	ss 1 and 2 of Health a item 27 Is		20a Method of Disposition 20b. Place of Dis	position (Name of Dat		Location - City or Town, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		1 XBuria: 2 Cremation 3 Removal from State	rematory or other place) son Forest 4-18-	2007 Ow:	ings Mills, MD
alti.	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee		rch F/H	7.7
m	permi Depar Impo any ir once.		I lady ware	1101 E. Nort		21202
ă.	E2 96		23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition a. HYPETTENS VE	ATHEROSCLER	COTIC	DISEASE
d	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
		-	Sequentially list conditions, frame leading to it mediate. b. Due to (or as a consequence of):			
	rted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
oʻ	cate be executed oblysician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	cate be	dical	d			
9	ng ph	Med	IF FEMALE:			
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pt pregnancy 1 Live birth 2 Fetal death	3 □ Ectopic pregnancy		23d. Date of delivery Month Day Year
<u>o</u>	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		
Δ.	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ds,	uires sign ld be	d by			1 🗆 Yes	2 No 3 Probably 4 Munknown
Ö	s beer	lete			24a. Was an	24b. Were autopsy findings available
Re	sician: The lar certificate has rector, page 2	Completed			autopsy performed? 1□ Yes 2☑1	prior to completion of cause of death? 1 □ Yes 2 □ No
<u>ta</u>	ian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (
<u>></u>	Physic this ce al direc	To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpat		e 5 Residence	6 □Other (Specify)
n c	Attending Physician: or death. ector: After this certification by the funeral director, I	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	y Work?	d. Describe how inj	jury occurred
Sio	ttend death. tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury - At home farm.	M 1 Yes 2 No	f Location (Street	and Number or Rural Route Number,
Division or Vital Record	I or Attene after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	orioti, laviory, office	City or Town, Sta	ate)
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Sal	29a. Certifier Chock only Ch			
	he He in 24 he Fu	edical	(Check only 2 Medical Examiner: On the basis of examination and/or one)		at the time, date a	and place, and due to the cause(s)
	To the I within 2. To the I complet	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
			44	D57357		4/11/0-/
	X		30. Name and address of person who completed cause of death (Item 23a) (Typ. AMIT KHOSLA, MA 3901 THE	e, Print) AI AMENA RAIT	IMORE	MD 2018
	Sta	te	31. Date filed (Month, Day, Year) 37. Registrar's Signature	D57357 ALAMEDA, BALT	/	[W - C C G
	Registr		APR 1 3 2007 Januar 15 Apr	ENL)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 1 4a c per doc 866 4-13-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gilbert Parkes Month 4 **Physician** 205 AM (Filbert 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ctr. 4c. County of Death **Examiner** Batt. Hopkins Bayview Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 18, 1930 **Funeral** Days Pennsylvania Director 196-22-6771 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 🕅 No Maryland Anne Director Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 87 Will-O-Brooke Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Machinist</u> Mate U.S. Coast Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilbert Parkes ဂ Sophie Orzechowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol <u>Parkes - wife</u> 87 Will-0-Brooke Dr., Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Grandview Cemetery April 5,2007 Johnstown,PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD 21122 23a. Part I. Enter the diseast, or complications that complete the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by artery disease 1 Yes 2 No 3 Probably 4 Unknown preumon 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy renal failure Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Eastern 4940 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death April 10, Day 2007 Year He1en Pagurek 3:30 p_M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton Crofton Convalescent Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) N.T 5. Social Security Number 6. Sex 8. Date of Birth Days Hours Months 1472471912 141-22-4294 1 ☐ M 2 🔀 F 94 NJ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Prince George's Bowie MD 1X Yes 2 No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 20715 12619 Kavanaugh Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dietician Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gorski Anastasia Peter Saganski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zio Code) 12217 Maycheck Lane, Bowie, MD 20715–1556 19a Informant's Name/Relationship (Type Print) Rita Pakulniewicz / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🙀 Removal from State 4/21/2007 North Arlington, NJ 4 □ Donation 5 □ Other (Specify) Holy Cross Cemetery 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 East Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 4 Rom Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performe 2X No 26. Place of Death (Check only one)

Physician /Medical Examiner

Department of H Important: If ite any Injury or ot once.

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Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after

of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical

altimore, Maryland 21215-0036

Examiner burial-tra physician s the burial Physician/Medical as nding pure þ Completed certificate has b irector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifical completely filled in by the funeral director, p Be 2 Certification:

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1**√**Matural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

2 ER/Outpatient 3 DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 Yes 2 No

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature

5 Pending investigation

29c. License number

29d. Date signed (Manth, Day, Year)

Name and address of person of death (Item 23a) (Type, Print) 438 Defense Huy

bhard 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Medical

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trai Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

show

ms 23a or 28a-f shor must be notified at

"natural", or item edical Examiner

the Medical

27 Is marked other er traumatic event, ti

Department of Health Important: If Item 27 any injury or other to once.

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Funeral

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Completed

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Physician/Medical ò Completed Be Certification: To Director: Funeral D

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESOCI APRIL, 11,

State Registrar

Medical

31. Date filed (Month, Day, Year)

WNOVER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

STREET, BALTIMORB, MARYL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2007 Francis Edward Ruppert 3:35 AM April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 18, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Year Months Days Hours 1**X**M 2□ F 79 220-20-6725 1927 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? *#*506 31 Lambourne Rd. 21204 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: Specify: 9 white 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumation. Printing Printing plate maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Joseph Ruppert Anna McGowan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Lambourne Rd. #506 Towson, MD 21204 Dorothy Ann Ruppert/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park Apr. 16,2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 Vork Rd Raltimore, MD 21212 Mitchell-Wiedefeld Funer 6500 York Rd. Baltimor 23a. P. M. 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician unting ancreance mcci /Medical Dus to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Bother (Specify) Woscille Hospital: 1 ☐ Yes 2/**C** No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. d □ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division or Vital Records, To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

31. Date filed (Month, Day, Year) State APR 13 2007 Registrar

29a. Certifier



and manner stated.

30. Name and address of person who, completed cause of death (tem 23a) (Type, Print)

N. Charles St

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

TONSON MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per flu 866 4-19-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:200 am lÓ 2007 ROTH BENJAMIN /Medical 4a Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner altimbe at 2th MOV N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F 03/09/1918 113-12-2106 NY 89 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Funeral Director BALTIMORE BALTIMORE MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9 POMONA NORTH #3 21208 U.S.A. 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 X Yes 2 □ N WW II If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 2 No Maryland 21-215-0036 1 ☐ Yes Specify. Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CITY OF BALTIMORE ADMINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ges 1 and 2 should be filk it of Health and Mental H If item 27 Is marked oth ROTHBLITH NETTIE RYSNICK HARRY P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other t BETTY ROTH / WIFE <u>9 POMONA NORTH #3 - BALTIMORE, MD 21208</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 ☐ Remøval/f@m State permit. Page:
Department o
Important: If i
any injury or SHAAREI TFILOH CONG. 04/11/207 WOODLAWN, MD 5 ☐ Other (Speqify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Funeral Service Li 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) osis **Physician** /Medical Due to (or as a consequence of): Examiner uti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f P.O. 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 → NO 3 □ Probably 4 □ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has l certificate 1□ Yes 2 → No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 1 Dinpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident the Funeral Director: npletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 63198 30. Name and address of person who eted cause of death (Item 23a) (Type, Print) 10

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 13

2007

ar Janes

07-02728 Sharon I. Rock Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sharon L Rock	E	- For State Registrar		ate of Maryla		artment o <i>tificate o</i> i		nd Mental F		201)7 18
Physician/ Medical Examine		SHARON			LEE		ROCK		2. Date of Deat Month April 10, 2	Day Year	3. Time of Death 1122 hrs
Funeral Director					ge (In yrs. last birthday)		4b. City, Town, or Location of Death Forest Hill Cockeysvi If Under 1 Year If Under 24Hrs Months Days Hours Min		4c. County of D Baltimore (Birthplace (State or preign MD	
		214-62-2944 1 M 2 X F 52 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo			Yrs Town or Locat			07/25/	1954	1954 Country) IND	
the Maryland a or 28a-f show any uffied at once,	בנוס	MD 10e. Street and Nu	mber	TIMORE		COCKEYS	10f. Zip Code		11	Og. Citizen of What (1 Yes 2 No
er death with , or items 23	ין מוונומו	11. Marital Status	ed 2 X Ma		2 X No			ispanic Origin? (S in, Mexican, Puert		White, et	merican Indian, Black, c. VHITE
5-0036 ed within 72 hours aft ed within 72 hours aft other than "natural" the Medical Examine Completed by	libiered by		lucation (Spec	or Dates: ify only highest grad	le completed)		it's Usual Occupa ost of working life	ation (Give kind of e. DO NOT use re		Specify: V 16b. Kind of Busine OWN HC	ess/Industry
21215-0036 Muld be filed within 7 Mental Hygiene marked other than e event, the Medica	a Re	17. Father's Name	, ,	,		CAVEY		ELLA	MAE	Maiden Surname)	JOHNSON
MD 2121 nd 2 should be fi alth and Mental m 27 is market raumatic event,			ROCK /	HUSBAND		13 SF	RING GL	EN COURT	- COCKE	SYSVILLE,	MD 21030
Baltimore, ME permit. Pages I and 2.8 Department of Health an Important: If item 27 injury or other traum		4 Donation 5 21. Signature of Fu	Cremation Other Sp			rematory or oth	lame and Addres	ERY 04/	SOL LEVI		OS., INC.
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Athoroccal protice, coordinate and disease.										Approximate Interval Between Onset and Death
ted Insit	Sequentially list conditions, if any, leading to immediate ease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):										
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cox 6876 eath certificat eath certificat for use as the	2	F FEMALE: 3b. Was decedent past 12 months 1 Yes 2 V	?	23c. If yes, o	outcome of pregr irth ant at time of dea	ancy 2 Fe	tal death 3 ner (Specify)	Ectopic pregn	ancy	23d Date of deli Month	very Day Year
, P.O. B res that the d signed by the be detached d by Phy		Part II. Other signi	icant condition	ons contributing to	death but not re	esulting in the u	nderlying cause	given in Part I.			e to the cause of death? Probably 4 Unknown
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F Vital Physician: r this certi al director To Be			2 No			ER/Outpatient	3 DOA		ng Home 5 I	Residence 6 🗸 O	ther: Scene
Division of a lital or Attending Phus after death. Tral Director: After the lited in by the funeral ertification: T		27. Manner of Deatl 1 X Natural 2 Accident	5 Pendi	ng tigation	Day,Year)	28b. Time of I	1	Yes 2 No		ow injury occurred	Devil Devil All serbes Chris
Division Hospital or Attent 24 hours after death Funeral Director: stely filled in by the	15	Suicide Homicide Sa. Certifier	deterr	nined (Specify)			et, factory, office		or Town, St	ate)	Rural Route Number, City
To the How within 24 h To the Fur completely		(Check only one) 2	Medical Exan	ysician: To the best niner:On the basis o and manner st			ion, in my opinio	n, death occurred		and place, and due to	o the cause(s)
		29b. Signature and	N	4/	111		29c. Licens	M.E.		April 11, 2007	Month, Day, Year)
e	3	Susan Hoga		who completed causessistant Medica	al Evanninas	111 Don	n Street, Bal	timore, MD 21	1201		
State Registra	-	31. Date filed (Mont.	PR 1 3	2007 32. 5	gistrar's Signatu	or do	W.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Da Year **Physician** 2:05 200, /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Avenue If Under 24 irs. 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign South Caroling 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2**X** F 20-26-0458 Usual Residence of Decedent Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itame 23s or 28s-f ehow the Medical Examiner must be nutified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? JSA tridge Avenu Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementa (75) condary (0-12) College (1-4or 5+) Department of Health and Mental Hygie Important: If item 27 Is marked other eny injury or other treumatic event, III ODCE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta to.MD 20a. Method of Disposition 20b. Place of Disc 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) l 6 21. Signature of Funeral Service Licensee lu 20 1212 2 POR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Tage Kchul /Medical Due to (or as a consequence of) Examiner Nighetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Block Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 No 1 Tyes 2 🗌 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 🗀 Yes 2 NO 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

JOHN STOKES 31. Date filed (Month, Day, Year)

3333 32 Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Oril 2007 am anle /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth Month, Day, Year 2. 192 -lon1e 7. Age (In yrs. last birthday) Yrs. 9. Birthplace (State or Foreign Qountry) Social Security Number 6. Sex, 1 M 2 □ F Funeral 216-14-0884 Usual Residence of Decedent Months Days Hours Min. Director Varuland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ∑Ves 2 No Director mor 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code a or items 23a 2 more death 1 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. 11. Marital Status 12. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or it 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Specify: Specify: Blac Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental I tem 27 is marked of William ၉ nomas Glady item 27 is marke other traumatic 19b. Mailing Address (Street and Number or Rur Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) daugnter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any Injury or c once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) CK ore. Name and Address of Facility 21. Signature of Funeral Service Licenses erai Home P.A. Baito, Md. 21216 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1 Enter the disease, or complications that shook, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) anythemias 20 minules **Physician** ardiac /Medical Due to (or as a consequence of): Examiner disease theresclerche 1044 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Hypertension 2044 Due to (er as a consequence of): Division or Vital Records, P.O. Box 68760, mellitue 444 Dicheles Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Demenha beinleinson allsease 1 🗌 Yes 2 **□** No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Colorecha Cancer 24a. Was an autopsy performed 2 No 2 1 No 1□ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ this I Director: After this of in by the funeral d 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) * DESAIM D304914 4-10-2007

State

716 Moudon cheice lone

32. Registrar's Signature

Clebras

Costenville mo 21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician YMedical** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. 1 M 2 □ F Months Days Hours Gountry | Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location State 10b. County 10d. Inside City Limits 1 Yes 2 □ No **Funeral Director** ITIMOre 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation Date 3 ☐Removal from State 200 4 □ Donation I 5 Other (Specify) renutory 22. Name and Address of Facility 21. Signature of Funeral Servige Licensee uneral Ho Hom Ave. 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ORONGRY /Medical Due to (or as a consequence of): **Examiner** en 10 n Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of): Due to (g)r by Physician/Medical Examiner de Due to (or)as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be

P.O. Box 68760 Division or Vital Records,

the Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, Certification: To 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) werek 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAIT, WEDPY LAWRENCE 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar 2007 DHMH 17 Rev 1/2001 **ORIGINAL**

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	Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of D Month		ay Year	3. Time of Death	
	/Medic		Vernon	Dale	S	ions			April	12,		6:19 pm M	
Ž.	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town, o	or Location of Dea	ath		c. County of Death		
_			1666 Cape May R		a /In vre I	ast birthday)	Essex If Under 1 Year	If Under 24 Hr	S. 8 Date of B	irth]	Baltimore 9. Birthplace (State or Foreign		
	Funeral Director		215–36–8327	1 X 1M 2□ F	66	Yrs.	Months Days	Hours Mir				intry) Virginia	
			Usual Residence of Decedent		00				3/17/	340	west	_ VIIGIIIA	
	yland how at	. [10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits	
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	ath w		1666 Cape May R				21221				S. A.		
	er de items	Funeral	 Marital Status Never Married Married 	12. Was Decedent Armed Forces? 1 ☐ Yes 2X		S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (oan, Mexican, Pue	Specify Yes or Nerto Rican, etc.)	0-	14. Race - Amer Black, White		
36	rs aft I', or xami	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	NO		1⊡Yes 2 ⊡X No	Specify:			Specify:	nite	
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ور	Pages nent of h int: If ite		1 XBurial 2 ☐ Cremation 3		C	emetery, crei	natory or other pla						
Baltimore, Maryland 21215-0036			4 □ Donation 5 □ Other (Special Service Lie		Gard	dens o	f Faith	Cem. U4/	11/200	/ (Overlea,	Maryland	
Ba	permit. Departr Imports any inj	-	21. Olgitature of 1 dicital de l'ivide Eli	Serisco	_	B	2. Name and Address 2. Nam	ki Funer Fastern	al Home	PA	ov Marv	Land 21221	
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68760,	tificate be executed g physician and as the burial-transit	ledical		d									
	certif ding se as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of deli	verv	
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0	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown									
Vital Records, P.O.	w requires that s been signed t should be deta	by Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							tobacco	cco use contribute to the cause of death?		
ğ	equire en sig								- 1] Yes	2 No 3 Pro	bably 4 🗹 Onknown	
သွ	has ber	plet							24a. Wa	s an	24b. Were au	topsy findings available ompletion of cause of	
E.	The ate his page	Completed								formed?	death?	2□ No	
/ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						eath (Check only	one)			
<u> </u>	hysik this call dire	은	1 ☐ Yes 2 ☐ X o	Hospital: 1 ☐ Inpati			I 3 DOA				6 □Other (Spec	eify)	
n	ding Physician: The Ing. The Ing. The Ing. After this certificate he funeral director, page	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ary Ny Year)	28b. Time o Injury	Wo		28d. Describe	how inj	jury occurred		
Sign	ttend death stor:	Certification:	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 280 Place of in	un/ - At bo	me farm str]Yes 2 □No	28f Location	(Street	and Number or Rural Route Number,		
Division or	lor A after o Direc	ertif	4 Homicide determined determined determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and City or Town, State)						ate)	rai rioute ivamber,			
	spita nours neral filled		29a. Certifier 1X Certifying	Physician: To the best	of my know	wledge, deat	h occurred at the t	ime, date and pla	ce, and due to th	e cause	(s) and manner as	stated.	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical E.	xaminer: On the basis of and manner s		tion and/or in	vestigation, in my	opinion, death oc	curred at the time	e, date a	and place, and due	to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier					se number			d. Date signed (Month, Day, Year)		
			1 gall	C MI)		RES	5-00	1	APP	IL 13,	2007	
-	10		1 - 0 -	ho completed cause of	death (Item	23a) (Type,	Print)		40			21287	
	\ Sta	to	JESLIE FECT 31. Date filed (Month, Day, Year)	IER, MD 6 32. Pegist	rar's Signa	NORT ture	H WOLF	E STRE	ET BA	LTI	CHORE	2007 21287 URYLAND	
	Registi		8 Th 10 -4	2007	AR A	K A	market						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12, 2007 Year **Physician** April 6:20 A.M Winifred Virginia ShaDell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5437 Channing Road Baltimore Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Months Director 214-14-8672 85 15, 1921 Virginia June Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the Martinal". 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 → No Director Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5437 Channing Road 21229 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Industry Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred C. McGuire Beulah Johnston 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5437 Channing Road; Baltimore, Maryland 21229
cs of Disposition (Name of Date 20c. Location - City or Town, State Theresa A. Lowry Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Cemetery 4/14/2007 4 Donation | 5 Dother (Specify) Baltimore, Maryland 22 Name and Address of Facility Sterling As ton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue: Catonsville, 23a. Part1. Enter the disease, a complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. I st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CONVO STORE Physician resulting in death) /Medical Due to (or as a conseque of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: use If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 morans' 3 ☐ Ectopic pregnancy should be detached for Month Day Year 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed ril car 2 25. Was case referred to medical examiner? in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1.☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar (Check only one)

29b. Signatu

le of ce

30. Name and address of person no completed cause of death (Item 23a) (Type, Print)

32. Hegistrar's Signature

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30631

Geipe Rd

29d. Date signed (Month, Day, Year)

Physician /Medical

the attending physician and

Department of Health and Mental High Important: If Item 27 is marked other any injury or other traumatic event, the once,

Physician

/Medical

Examiner

10a. State

Funeral

Director

items 23a or 28a-f show iner must be notified at

'natural",

Director

Funeral

þ

Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Examine

Physician/Medical Completed by Certification: To Be within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed

After this

Division or Vital Records, P.O. Box 68760,

shock, or heart failure. List of	only one cause on each line.		Onset and Death					
Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immisdiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months? 1							
Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?					
Pulmonar.	Edemen	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \sum Yes 2 \sum No					
25. Was case referred to medical	26. Place of Dea	th (Check only one)						
examiner? 1 ☐ Yes 2 ☐ ₩ő	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 ☐ Residence	6 □Other (Specify)					
27. Manner of Death 1 Natural 5 Pending 2 Accident investig	ation M 1 ☐ Yes 2 ☐ No	(Month, Day Year) Injury Work?						
3 Suicide 6 Could n 4 Homicide determi		28f. Location (Street a City or Town, State	8f. Location (Street and Number or Rural Route Number, City or Town, State)					
	g Physician: To the best of my knowledge, death occurred at the time, date and place Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.							

29d. Date signed (Month, Day, Year)

Registrar

State

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lawrence Jacob, M.D., 2001 Medical Parkway, Annapolis, MD 21401

00062964

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Ruth Dorothy Seylaz 9:30 PM Apri 10 2007 /Medical 4a. Facility Name (If not institution, give street and number)
Harford Memorial Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Havre de Grace If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 02/14/1930 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign
 NJ Country) **Funeral** 10M Days 150-22-4114 Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene.
7 is marked other then "naturel", or Iteme 23a or 28a-1 show traumatic event, the Modical Examinar must be notified at 1 Yes 2 No MD Harford Belcamp Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 21017 4312 Downs Square USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 29 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedenl's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker t7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be finance and Mental H William Abline Caroline Heilman permit. Pages 1 and 2 s. Department of Health and Important: If Item 27 is my only injury or other. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informani's Name/Relationship (Type, Print) Carol Weil/Daughter 4312 Downs Sq. Belcamp, MD 21017 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory Inc. 2007 20c. Location - City or Town, State Apr 13 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Eremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Injerval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) multi system organ **Physician** /Medical Examiner inflamma to enic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner iere Director. After this certificate hes been signed by the attending physicien and filled in by the funeral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 month's? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Hnpalient 2 ER/Outpatient 3 DOA 28b. Time of Certification: 27. Manner Death 28c. Injury al Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel of within 24 hours af To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) G755222 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harra De brace SOIS WARON A Little aul 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 3 2007 20161 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Paul Donald Sonner April 7, 2007 9:30 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours **1**X M 2 □ F 106-01-2029 6, 1914 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1311 K Scottsdale Drive 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2½ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Proofreader Printing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul (unk) Sovinsky Mary (unk) Krajcer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Lee Coon / Daughter 718 Chambers Circle, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp: 4-10-07 4 □ Donation 5 □ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Il Sly 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2,**K** No 25. Was case referred to medical examiner? Hospita 1 ☐ Yes 2 No dence 6 □Other (Specify) 27. Manner of Death

Physician /Medical Examiner

burial-transi

the

the attending physician

been signed by

certificate

After this

within 24 hours after death

To the Funeral Director:

law requires that the death certificate be executed

P.O.

Records,

Division or Vital Hospital or Attending Physician: **Physician**

/Medical

Examiner

Directo

Funeral

9

Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or from any injury or other trainmant.

Examine Physician/Medical Completed by Be Certification: To IF FEMALE: 9 Unknown

			26. Place of Death (Check only one)						
ll: 1 ☑Inpatient 2 ☐	ER/Outpatient	3□ DOA	Other:	4 ☐ Nursing H	ome	5 ☐ Residence	6 □Other		
a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?		28d.	Describe how inju	ury occurred		

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

602 S. A-WOOD Rd, BELASR MD 21014

29a. Certifier (Check only one)

29b. Signature and title of certifier

1 Natural 2 Accident

3 Suicide

4 Homicide

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D 0056607

MiD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

29d. Date signed (Month, Day, Year) 8# 2007

State Registrar

ANGEL 32. Régistrar's Signature 31. Date filed (Month, Day, Year) APR 13

5 Pending investigation

6 Could not be determined

205,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 **Physician** APRIL 7:35 A.M. LEONA MAE SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🔀 F Director 88 Jun. 29, 1918 Kentucky 405-01-1112 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Belcamp 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 1403 Sage Lane 21017 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify þ 3 ₩idowed 4 Divorced Year or Dates: "natural", White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 should be filed w h and Mental Hygier 7 **is marked other t** Homemaker 12 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlotte (unk) Herchfelt Samuel (unk) Phillips မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1403 Sage Lane, Belcamp, Maryland 21017 Sharon L. Fox / Daughter 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1
trant of F
tant: If it 1 Buriel /2 □ Crematic 3 □Removal from State Department of Important: If any injury or once. 4 □ Donayion 5 □ Oth (Specify) 4-12-07 Gardens of Faith Cem. Baltimore, Maryland 22. Name and Address of Facility
McComas Funeral Home, P. A. 21. Sign of Funeral 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ereprovas disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or de a consequence of) Examiner that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 Tes 2☐No 3☐ Probably 4☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform page certificate 1□ Yes 2 E No Physician: 25. Was case referred to proical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: Division or Attending atural Injury 5 Pending s after dea. 1 ☐ Yes 2 ☐ No 2 Accident Investigation To the Hospital or Aux...
within 24 hours after deat

To the Funeral Director 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 defitiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier

State

Registrar

ABERDEEN,

21001

MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANUEL LAZATIN

31. Date filed (Month, Day, Year)

APR 1 3 2007

8 LAW STREET

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 11 17

Physici		Decedent's Name		t)				0110			2. Date of De Month	Day	Year	3. Time of Dea
/Medic	cal	FAY		atmat and numb			SHAS		Location o		APRIL_	10	2007 County of Deat	11:20
Examir	ner	4a. Facility Name (If I			91)		40. City,		REIST		OMN	10.		ALTIMORE
uneral		5. Social Security Nu	mber 6. Se	7.	Age (In yrs. Ia		If Under	1 Year	If Under		8. Date of Bi	rth		thplace (State or Fo
rector		080-28-18		□M 2 X F	71	Yrs.	Months	Days	Hours	74111.	12/22/	935		NY
×	1	Usual Residence of I	Decedent 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Li
feb	ţ	MD	BALTIMO	RE		REISTE	ERSTON	νN						1 ☐ Yes 2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #4b-c, perMD, geo, 4713/00/11 Department of Health and Mental Hygiene Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** SIDNEY Sm177 2007 /Medical ity, Town, or Location of Death **Randal Istown** 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Nostrivest BALTIMONE Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 ☐ F 100-01-7327 92 07/25/1914 Director Usual Residence of Decedent Sa or 28a-f show t be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ms 23a 3800 OLD COURT ROAD 21208 U.S.A. Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White etc. e filed within 72 hours after of Hygiene.
Al Hygiene. "natural", or iter 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 M Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ATTORNEY LAW 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental P DELAGUDIN SMITH MOLLY SOLOMON Pages 1 and 2 should nent of Health and Mer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health em 27 | 5 GARRISON FARMS COURT - BALTIMORE, MD 21208 JOEL SMITH / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o once. 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CONG: 04/11/2007 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician orlandvissin disease or condition resulting in death) /Medical to (or as a consequence of): Examiner nearly as Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): Box 68760. physician s the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autop performe 21 page 2 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 D Natural 2 Accident 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 2007. MA

State Registrar

Ollem 31. Date filed (Month, Day, Year) 3 200

30. Name and address of

LINDKN

30 Hos Signature

erson who completed cause of death (Item 23a) (Type, Print).

Dane, Glan Binne - mis 21001.

			1 - For State Registrar	State of	f Maryla	•	artment of H		- 1	giene 0	07	11827
		v	1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month		Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution,				4b. City, Town, or	r Location of Death		4c. Count		1
			ST. JOHN'S 5. Social Security Number			'ER s. last birthday)	BALT If Under 1 Year	IMORE If Under 24 Hrs.	8. Date of Birtl		I/A	plana (State or Foreign
	Funeral Director		087-14-1893	1 M 2 M F	86	Yrs.	Months Days	Hours Min.	DEC. 1	, 1920	NEW	place (State or Foreign intry) YORK
	pu *		Usual Residence of Decedent 10a. State 10b. County		100.0	City, Town or Lo	cation					10d. Inside City Limits
	ehov	ō		I/A	100.0	BALTIM						1 XYes 2 No
	the N	Director	MD N	/ A		DALITI	10f. Zip Code			10g. Citizen of	What Cou	untry?
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Маг	d 2 sh h and 7 Is m treum		19a. Informant's Name/Relationshi MICHAEL WOYTOW		uem		ng Address (Street a MATTHEW					
ā,	1 and Healt tem 2		20a, Method of Disposition	ICZ/NEF		Place of Dispo	sition (Name of		Date DALI	20c. Location		
Ē	Pages nent of int: If it		1 XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		State ST		natory`or other plac IAEL [†] S U		N 4/14	/07 BA	LTI	MORE, MD.
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DIVISION	Atten r dea ector: by the	Certification:	3 Suicide 6 Could no	t be 28e. Place	of Injury - At	home, farm, str	eet, factory, office				ber or Rui	ral Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier 1 Certifying (Check only	Physician: To the kaminer: On the ba and man	best of my ki asis of exami ner stated.	nowledge, death nation and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the d red at the time, o	cause(s) and m date and place,	anner as , and due	stated. to the cause(s)
	To the To the comp	W	29b. Signature and title of certifier	el	u =	WS	29c. Licenso	e number 52.430		29d. Date signe		, Day, Year)
	6		30. Name and address of person w	ho completed caus	e of death (It	em 23a) (Type,	Print)	sternA	e, p	elto. 1	MD	21224
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 5:55 PM DONNA 200 +Ori /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Memorial Union Hospital Honore NIA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec 8, 196/ 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 🔀 F 220-82-4017 Hours York Director New Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liujury or other traumatic event; the Medical Examiner must be notified at anone. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 Yes 2 No Maryland Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Crofton 21239 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □ Yes 21/2 No Specify. Specify: Black þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salon eautician 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be 2 Iberia Sanders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sanders Lbaria Mc Collough - Mother 614 Circle MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-16-2007 Randellstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN L, WILLIAMS F.S. PA almi J. h 644-PO Box 1165 Baltimore, Md. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as/a consequence of): **Physician** one month /Medical Examiner AIDS year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 1 Natural сотрете filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M,D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State of Maryland / De Registrar	partment of Hertificate of L			ene2 0 0 7	11829
	*Physici		1. Decedent's Name (First, Middle, Last) Carmita Schildhauer			2. Date of Death Month March 31	Day 2007 Year	3. Time of Death 9:25 PM M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	March 51	4c. County of De	
*:			Pickersgill Nursing Home	Towson			Baltin	
ı	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ▼ F 100 Yrs. last birthda 7. Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Bi	rthplace (State or Foreign Country) Insylvania
	D		Usual Residence of Decedent			Bept 25,	1300 101	
	Maryla f ehov	ō	MD Baltimore 10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2√ No
	or 28e-	Directo	10e. Street and Number	10f. Zip Code		10g	. Citizen of What C	
	ath wi	ralD	615 Chestnut Avenue		1204		USA	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23a or 28e-f ehow eumetic event, the Madical Exam for must be mailified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ♥ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2√ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
2-00	72 hou	ted	15. Decedent's Education 16a. Dec	cedent's Usual Occupa	ation	16	b. Kind of Busines	s/Industry
121	within and.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done of DO NOT use retired		mg	1.	
2	illed v I Hygie other i	Be Co	12 0 17. Father's Name (First, Middle, Last)	housewife		e (First, Middle, Ma	OWN home iden Sumame)	2
ylar	Menta Menta arked etic ev	To B	Fredric Kennedy		Ма	ry March		
Mar	d 2 sho th and 7 Is m treum		1	iling Address <i>(Street a</i> l South Wi			-	
Baltimore, Maryland 21215-0036	Pages 1 and 2 should nent of Health and Men ont: If item 27 Is marke iry or other treumetic		20a Method of Disposition 20h Place of Dis		1		c. Location - City o	
Balti	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licensee Ronald S. Wale lixector	22. Name and Addres State Anato Baltimore,		_	Baltimore	Street
	Physician /Medical Examiner	Examiner	23a. Par 1. Enter the disease, or complications that caused the death. Do not eshob, or heart failure. List only one cause on each line. Immediate Cause (Final disease or sondition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nter the mode of dying	g, such as cardiac			Approximate Interval Between Onset and Death
. BOX 68/60,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Exa	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□Ectopic pregnancy			23d. Date of de Month	elivery Day Year
J.	hat the d by th fetache	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	undarkting acuse ave	on in Don't	220 Did tabas	una una gentributa l	to the cause of death?
rds,	w requires that the dealt been signed by the atte should be detached for	ed by	Demention megacolon	with	on in Faiti,			robably 4 Unknown
Vital Record		Completed	pseudo. obstruction			24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ont 3 DOA Othe		(Check only one)		
on or	nding Phys th. : After this funeral dir	-	1 Yes 2 No No 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time 1 Natural 5 Pending 2 Accident Investigation 2 Accident 2 Reform 2	of 28c. Injury Work	4 Nursing no	me 5 Residenc 28d. Describe how		ecify)
DIVISION	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office		28f. Location (Stree City or Town, S	t and Number or F State)	lural Route Number,
	he Hospit n 24 houn he Funera pletely fille	edical (29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, dei 2 **Medicel Examiner: On the basis of examination and/or and manner stated.	ath occurred at the tim investigation, in my op	e, date and place, pinion, death occurr	and due to the caus ed at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier Marthy Mily, und	29c. License D J 3	number 5205	29d.	Date signed (Mon	th, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type Will A. R. Ley C. Brac 67° (N	Print) Charles	St. 6	Balto. 1.	nd 212	206
	° Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2007	perts)				

Christopher Andre	1		tate of Maryla	nd / Depa		Health and		Hygiene	gible.	007	11830
Physiciar Medical Examin	1/	1. Decedent's Name (First, Midd Christopher		tt				2. Date of Dea Month March 16	ath	'ear	3. Time of Death 1200 hrs
		4a Facility Name (if not institution 4020 Old Frederick R	on, give street and nur			4b. City, Town, or L Baltimore	ocation of Dea			ty of Death	
Funeral Director		5 Social Security Numbeank		7. Age (In yrs. Ia	ast birthday) 7 Yrs	If Under 1 Year Months Days	If Under 24h Hours M	in.	rth(MM/DD/YY	Foreig	thplace (State or unk in untry)
id how any		Usual Residence of Decedent 10a, State 10b, County MD			Town or Locati	imore		1141			10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 4020 Old Free	lerick Road	 1		10f. Zip Code	21229		10g Citizen of	What Cour JSA	ntry?
er death w	by Funeral	1 Never Married 2 N 3 Widowed 4 Di	flarried Armed Fo 1 Yes vorced If Yes, Give Year or Dates:	2 No	ink fy	s Decedent of Hispes, specify Cuban, Yes 2 X No	Mexican, Puer specify	to Rican, etc.)	S <i>pecif</i>	hite, etc y: w h	can Indian, Black,
215-0036 be filed within 72 hournatal Hygiene. rked other than "natu	mpleted	15. Decedent's Education (Spe Elementary/Secondary (0-12) unk	College (1-			t's Usual Occupation ost of working life.	DO NOT use r	etired)	16b. Kind of		
21215- ould be filed I Mental Hyg s marked out ic event, th	8	17. Father's Name (First, Middle 1998) 19a. Informant's Name/Relation:			19b. Mailing	unk 1		ne (First, Middle, r Rural Route Nu			unk
iore, MD ges 1 and 2 sho tt of Health and i: If item 27 is other traumati		O.C.M.E. 20a. Method of Disposition 1 Burial 2 Crematio		om State		enn Stre ition (Name of cem ner place)		Date Date	MD 212 20c. Locatio		Town, State
Baltimore, permit. Pages la Department of He Important: If ite injury or other transparents of the pages and the p	l	Donation 5 X Other S	License	irector	Ba1	lame and Address timore,	MD 212	201			Street
Physician Examiner	Examiner	23a Part I. Enter the disease, of allure. List only one caust Immed in Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	e on each line. a Atherosc Due to (or as a b. Due to (or as a c.	clerotic of consequence of	cardiovas n:	ne mode of dying, s scular disea		c or respiratory an	rest, shock, or	heart	Approximate Interval Between Onset and Death
execu an and al - tra	蕳	events resulting in death) Last	d	onsequence o)/07 TT					
Box 68760, e death certificate be the attending physicial drives as the burned for use a	sician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Ur	the 1 Live bi	outcome of pregi irth ant at time of	₂ Fe	tal death 3 her (Specify)	Ectopic preg	inancy	23d. Date Month	of delivery	/ Day Year
ords, P.O. Be w requires that the de is been signed by the should be detached f	2	Part II. Other significant condi	itions contributing to	death but not re	esulting in the u	ınderlying cause gi	iven in Part I.	1 Ye	an 24t	3 Prob	the cause of death? pably 4 Unknown topsy findings available completion of cause of
ital Recol	e Completed	25. Was case referred to medic	al			26.Place	of Death (Chec	1 🗸 Yes	ormed?	death?	
f Vi Physi er this	ation: To Be		Hospital: 1 Ir 28a. Date (Month, estigation	of Injury Day,Year)	ER/Outpatient 28b. Time of I	njury 28c. Injur	Other ₄ Nur y at Work? es 2 No	28d. Describe	Residence 6	urred	
Division Hospital or Attent 24 hours after death Funeral Director: stely filled in by the	al Certification:	3 Suicide 6 Cou				et, factory, office bu		or Town,	State)		ral Route Number, City
To the Hosp within 24 ho To the Funn completely		one) 2 Medical Ex. 29b. Signature and title of certif	aminer: On the basis of and manner strier	POUR 1	2	29c. License	number	d at the time, date		igned (Moi	e cause(s) nth, Day,Year)
Sta		Margarta Korell MD. 31. Date filed (Month, Day, Year	Assistant Med	dical Examin		enn Street, Ba	altimore, MI	D 21201			
Registr	_		5 CUU/1 ST		ORIGINA	L		<u>.</u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John Andrew Turchin 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square t0s Koseda bita Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 09/22/1922 Birthplace (State or Foreign Country) **Funeral** Days **X**XM 2□ F Months Hours Min 166-16-4937 Director 84 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2\\X\\\No Director Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2111 Hawthorne Road 21220 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWI] 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: WWII 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other thar 11 Machinist Aero-Space 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (s 1 and 2 should be fi Health and Mental I-Andrew Turchin Nellie unk. ပ injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health as Important: If item 27 Is any injury or other trauone. Veronica Turchin (Wife) 2111 Hawthorne Road, Baltimore, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 04/14/2007 Baltimore, Maryland 22. Name and Address of Facility Ski Funeral Home, P.A. 21. Signature of European Levillo Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate cruse (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mighty that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MOHON 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 X No 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death, neral Director: / filled in by the fi 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1th Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year)

140

DHMH 17 Rev 1/2001

State Registrar 9000 Franklin Square

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar'

			For State Ragistrar	State of I	Maryland /		artment rtificate					giene	7	11832
	Dhi.i.i		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea		Year	3. Time of Death
	Physici /Medic		Lawrence		Taylor							01/2007		8:55 A ^M
	Examir	er	4a. Facility Name (If not institution	•	ər)				Location of	of Death		4c. County of		
			P.G. Hospita 5. Social Security Number		Ass //s um local	h takka atau at	-	eve		24 Hrs	0. Date of Bird	Prince		
ı	Funeral Director		Unknown	1 M 2 ☐ F	Age (In yrs. last I 44	Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Day 02/09	/ 1963	9. Birthp Cour	place (State or Foreign htry)
			Usual Residence of Decedent		11						02/07	/1703		, c
	nytane how		10a. State 10b. County		10c. City, To								1	0d. Inside City Limits
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	ter dea itema	'n	11. Marital Status Never Married 2 Mar	Armed Force	s?	13.	If Yes, spec	fy Cuba	n, Mexican	n, Puerto	cify Yes or No- Rican, etc.)	Black	, White,	etc.
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E			1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		RESU	RRE	CTÍON	CE	M. 0	4-1	1-2007	CLINTO	ON,	MARYLAND
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<u>m</u>	89789		Fronald	Cay I		110	08 W.	NO	RTH	AVE	NUE, B	ALTIMO	RE,	MARYLAND
ı			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one danke on each	ed the death. De line.	not ent	ter the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
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89	ntifica ng ph	Med	IF FEMALE:										- 17	la la
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	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of death	5[Other (spe	ecify)			-	IVIOIT		Day Tour
P.0	that the de led by the a		Part II. Other significant condition	ons contributing to death	n but not resulting	in the u	nderlying ca	use aive	n in Part I.		23e. Did to	bacco use contri	bute to th	ne cause of death?
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sio	Attending r death.	cat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	gation			М		′es 2 🗆 !					
Division of	or At after of Direct in by	Certification:	4 Homicide determ	inod 200. Flace UI	Injury - At home, etc. (Specify)	farm, str	reet, factory,	office		2	8f. Location (S City or Tow	Street and Numbe m, State)	r or Rura	al Route Number,
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	To th Within To th comp	Me	29b. Signature and title of certifie	la .	1 ~		29c.	License	number		:	29d. Date signed	(Month,	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29 of the of Way 1866 / Department Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** April 11 Day 2007 ear Dona1d R. Terrien 8:15 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 313 Valley Court Road **Baltimore** Lutherville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 08/13/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 374-20-1442 1**⊠**M 2□ F 80 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside Cify Limits 28a-f show IL Dupage Naperville 1 XYes 2 No Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 312 East 11th. Avenue 60563 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽENo If Yes, Give Year or Dates: 14. Race - American Indian 'natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes **2**CNo Specify Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic event, the Many Injury or other traumatic event, the Many Injury or other traumatic Chemical Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Terrien Ray Florence Albers ဂ္ 19a. Informant's Name/Relationship (Type. Print)
Liz Soper / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
313 Valley Court Road, Lutherville, MD 21093 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Assumption Cemetery 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State April 28,2007 Wheaton, IL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility
Charles L. Stevens Funeral Home Inc. Donata W- Moustral 1501 East Fort Avenue, baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Doe to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. 1ther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 X Other (Specify) residence 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Expertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 11,2007 who completed cause of death (item 23a) (Type, pint) 32. Regis 31. Date filed (Month, Day ar's Signature State Registrar

ORIGINAL

			Please Type of Print in Black Indelible ink. Ensure	•	
			State of Maryland / Department of Health and	i Mental Hyg	nene 017 1831
			Registrar Certificate of Death		eg. No.
	Physic	an.	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Day Year
	/Medi		Thomas Rucker Trafton Jr.	APRIL	09 2007 8:40
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	ath	4c. County of Death
		A STATE OF	LORIEN-BEL AIR BEL AIR		HARFORD
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Yrs Months Days Hours Mi		Year) 9. Birthplace (State or Foreign Country)
	Director		348-01-2598 86	Oct. 11	, 1920 Kentucky
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
,	Aaryi.	5			1 ☐ Yes 25② No
26	the A	ect	Maryland Harford Fallston 10e. Street and Number 10f. Zip Code		Og. Citizen of What Country?
17	with a or	ā			
10	urs atter death with the Maryian at, or itema 23a or 28a-f ehow Examinat must be notified at	Funeral Director	416 Whitaker Mill Rd. 21047 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	USA 14. Race - American Indian,
5	ler d	P.	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White, etc.
Œ,ĕ	al', or	b	3 □Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ☒No Specify:		Specify: White
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	I within 72 ho lene. r then "natul the Medical	ple	(Specify only highest grade completed) (Give kind of work done during most of work done during	vorking	
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<u>_</u> ~	Mental Merked o	10	Thomas Rucker Trafton Sr. Lula M	Iiriam Cla	V
a S	d 2 should th and Men 7 Is marke traumatic	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Number	; City or Town, State, Zip Code)
5 ≥	1 and 2 Health em 27 I		Doris A. Trafton/ Wife 416 Whitaker Mill R	d., Falls	ton, MD 21047
T e	2 5 5 0		20a. Method of Disposition 1 Se Burial / 2 □ Cregnation 3 □ Remover from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
Æ Ĕ	permit. Pages Department of Important: If it any injury or o			-14-07	Forest Hill, Maryland
Q =	permit. Departr Imports any inju		21. Signature of Funeral/Service Licensed 22. Name and Address of Facility		St 10.8
	89 = 9		McComas Funeral H	Abingd	on, Maryland 21009
			23a. An1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card hock, or heart failure. List only one cause on each ling.	lac or respiratory arr	est, Approximate Interval Between
	Physician		Immediate Cause (Final	noma	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of)	TORRICA	
	Examiner		Sequentially list conditions b.	Letter	bleeding
	D =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
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3 ×	ath certificate ttending physi for use as the t	Me	IF FEMALE:		
)// Bo	attend attend	lan/	23b. Was decedent pregnant on the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
0	the a	slc	1 Yes 2 No 9 Unknown 5 Other (specify) 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2		
<u>а</u> .	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached tor use as th	Completed by Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tol	bacco use contribute to the cause of death?
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Sec.	e law has t	du	rumonary Disease	24a. Was a autops	prior to completion of cause of
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Division	하는	Certification:	4 Homicide determined building, etc. (Specify)	City or Town	
	spita ours seral		29a. Certifier 1 p entitying Physicians To the best of my knowledge death occurred at the time, date and pla	roo, and due to the m	susafe) and wannar as stated
	Ho 124 Fu	Medical	(Check only and manner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	courred at the time, d	ate and place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month, Day, Year)
			Mamily Uno Digte	13 1	April a 2207
1	$\langle x \rangle$		30. Name and address of person who completed cause of thath (Item 23a) (Type, Print)	Cheart'	THE TOUT
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	Sta		31. Date filed (Month, Day, Year) Registrar's Signature	wing low.	x = 1007
	Registi	rar	APR 1 3 2007 Realis to Appeal of	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Year. Irquhart 19:05 PM William /Medicat 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltmore City

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, 1930)

Apr 8, 1930 Examiner HODKINS 6. Sex 7. Hospital 9. Birthplace (State or Foreign Country) 1171k 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F unk 76 Vrs 214-26-8311 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itams 23a or 28a-f show the Modical Examiner must be notified at 1 Yes 2 ☐ No MD **Funeral Director** Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3939 Roland Avenue 21211 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.\$1nk | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? | 14 Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white à 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Is marked other th any injury or other traumatic event, the once. unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 N. Wolfe Street Baltimore, MD Johns Hopkins Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State `4 □Donation 5 MOther (Specify) in state 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Licensae RONALDS Wade Director 21201 ma baltimore, MD BALTIMOTE, MD 21201

231. Part 1. Enter the disease, or a mulications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and De 2 and and Death Immediate Cau e (Final disease or condition resulting in death) days **Physician** pneumonia /Medical ue to (or as a consequence of): Examiner aspiration Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death cartificate be axecuted burial-transit ischemic resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 🗷 No 1 Yes Division of Vital To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how înjury occurred Certification: 1 Natural 5 🗌 Pendina within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier RES-000 Banañano MoiPhD who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Krighin Barañano MD, PhD 600 N. Wolfe St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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E	Funeral		5. Social Security Number		Age (In yrs. Ia	ist birthday)	Catonsv If Under 1 Year	If Under 24			altimore thplace (State or Foreign ountry)
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	filed within 72 hours after death with the Maryland Hygiens other than "naturel; or Items 23s or 28e-f ehow ent, the Macical Examiner must be natified at	Funeral Director	1220 Elm Road				21227	•		USA	
	ems Ser un	Iner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S	i. 13. \	Was Decedent of H	lispanic Origin an. Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit	
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Z	2 a a a		19a. Informant's Name/Relations Susan C. Voslo		r				tus, Maryla	r, City or Town, State, I	Zip Code)
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a	permit. Pa Departmen Importent: eny injury once.		21. Signatur, of Funeral Service		Lou	22	. Name and Addre	ss of Facility		ineral Home	
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П			23a. Part. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. line.	Do not ent	er the mode of dyin	g, such as ca	rdiac or respiratory arr	est,	Approximate Interval Between
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o.	at the de by the a tached	yslc	1 ☐ Yes 2 12 No 9 ☐ Unknown	4□Pregnant 9□Unknown		atn 5∟	Other (specify)				
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	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifier 1 Certifyii	ng Physician: To the bes	st of my know	ledge, death	occurred at the tin	ne, date and p	place, and due to the c	ause(s) and manner as	stated.
	To the H within 24 To the For	ledical	one)	Examiner: On the basis and manner s	stated.	on and/or inv					
	viit To Con	Σ	29b. Signature and title of certifie	7			29c. License			9d. Date signed (Mont	
•			1000	Cursine		-0.1	D19	106)		4-9-200	1.
	10		30. Name and address of person					tonsv	ille, Md. 2	21228	
	Sta	te	Medical Directo 31. Date filed (Month, Day, Year)	or, 5743 Edm	ondsta	Ave	nue, Ca	V.			
	Registr		APR 1 3 2	or, 5743, Fdm	St.	Grand	20				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1905 PM **Physician** BIANCA ELIZABETH VALASCO 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CROSS HOSPITAL PR ILURR J 601 MONTGOMERY If Under 1 Year 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1 □ M 2 🛛 F Months 104 2007 Director MARYLAND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 Nes 2 No must be notified BELTSV **Funeral Director** MD COUNT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 44 HM 20910 AUE USA items 23a 1041 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. MaritaJ Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 0 Specify: Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Menta OBED VILLAFUERTE VALASCO VILLAFUERTE 1502B ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FOREST GLEN RD SILVER SPRING MD HOLY CROSS HOSPITAL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₩Other (Specify) in state 21. Signa ur + of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street rector 21201 Baltimore, MD 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Juse (Final disease or condition) Approximate Interval Between Onset and Death Physician XTREME PREMATURIT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SR COLI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed INTRAVENTRICULAR HEMORRHAGB use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1'√Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To this filled in by the funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

DAWN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

WAI

MD

32. Signature

DHMH 17 Rev 1/2001

1200

FOREST

29c. License number

GLEN

29d. Date signed (Month, Day, Year)

SILVER

			For State	State of Maryla		artment <i>rtificate</i>			and Me			0000	ï	11029
			Registrar 1. Decedent's Name (First, Middle, Last)			Timodic	0, 2	Journ		2. Date of Dea	Reg. No	7 1111	3	. Time of Death
	Physici		Joseph Carl Weimas	ter						Month AFR	Da T I	y Year 7. 220		3:10 AM
	/Medio		4a. Facility Name (If not institution, give s Saint Joseph I	street and number)	nter	4b. City, T	own, or	Location o	of Death			. County of De	ath	nore
B	Funeral Director	la.	5. Social Security Number 6. Sex 216–16–9037	7. Age (<i>In yr</i>	s. last birthday, Yrs.		1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birtl (Month, Day Oct. 2	y Year	^{9. в} 1921 Ма	irthplace country) LYL	e (State or Foreign and
	ъ "		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or L	ocation							104	Inside City Limits
	shov shov	7	Maryland Baltimore		ckeysv.									1 ☐ Yes 2 📉 No
	the M	ect	10e. Street and Number	. country co	CICCY 5 V	10f. Zip (Code				10a Ci	itizen of What C	Country?	,
	with ta or		10603 Topsfield Dr	rive		210						ited St	-	
	ms 23	Funeral Director		12. Was Decedent Ever in	U.S. 13.			spanic Ori	gin? (Spec	cify Yes or No- lican, etc.)		14. Race - Am	nerican I	
က	after o	Ξ	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 X Yes 2 □ No					i, Puerto R	lican, etc.)		Black, Wh		_
03	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	IXI NO	Specify:				Specify: W	UTE	
5-0	72 h "natu dical	etec	15. Decedent's Educ (Specify only highest grade	cation co <i>mpleted)</i>	16a. Dece (Give	edent's Usual e kind of work DO NOT use	l Occupa k done d	ation <i>Juring mos</i> i	t of workin	g	16b. k	Kind of Busines	s/Indust	ry
21215-0036	12 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Manu:	factur	ing	Engi	neer		We	stingho	use	Electic
d 2	filed Hygie other	ပို	17. Father's Name (First, Middle, Last)	<u>د</u>			T	18. Mothe	r's Name	(First, Middle,	Maide	n Surname)		
lan	id be ental ked c	To Be	Joseph Carl Weimas	ter				Marga	aret	Perego	У			
Maryland	shou and M amar umat		19a. Informant's Name/Relationship (Type	pe. Print)	19b. Mail	ing Address	(Street a	and Numbe	er or Rural	Route Numbe	er, City	or Town, State,	Zip Co	de)
Ž,	and 2 saith a 1 27 is		Mr. James Weimaste	er (Son)	16 N	orthwo	od I	rive	, Tim	onium,	Ma:	ryland	2109	93
Ore	of He fitem		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ R		. Place of Disp cemetery, cre	osition (Namematory or ot	e of ther plac	e)	Da	ate		ocation - City o		
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Specify)	Du	laney '			i_		2,2007	Τ.	imonium	,Mar	cyland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	ee V	Pe 2	2. Name and eacefu 325 Yo	d Addres il Al ork E	s of Facilit Lterna Road,	ative Timo	s Fune nium, 1	ral Mar	&Cremat yland 2	ion 1093	Ctr.,P.A
2,092	Physician hysician and hysician and hysician and the burial-transit	dical Examiner	23a. Pant1. Enter the dise se, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CONGESTI Due to (or as a cons ISCHEMIC Due to (or as a cons Due to (or as a cons	VE HEP equence of): CARD I equence of):	RT F	AILU	JRE					Int	proximate erval Between nset and Death
P.O. Box 68	death certific e attending p id for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf preg 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pre						23d. Date of d Month	elivery Da	y Year
	requires that the een signed by th rould be detache		Part II. Other significant conditions cor	ntributing to death but not r	esulting in the I	underlying ca	use give	en in Part I.		23e. Did to	bacco	use contribute	to the c	ause of death?
ord	equire en sig ould b	ed t	SEPSIS							1 🗆 \	es 2	2 XNo 3 □	Probabl	y 4 Unknown
Reco	e la has je 2	Completed by	AORTIC STENOSI	S							sy rmed?	prior to death	comple?	findings available etion of cause of
ta			25. Was case referred to medical					26 Place	of Death	1 Yes (Check only o	2 N	o 1 Ye	es 2	No
>	Physician: this certific al director,	To Be	examiner?	lospital: 1 npatient 2	☐ ER/Outpatie	ent 3 DO	A Othe	or:				6 □Other (St	pecify)	
Division or Vital Records,	nding Ph ath. r: After thi e funeral	ation: T	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28	Bc. Injun Work		2	8d. Describe h	_			
Divis	al or Atte s after des al Directo ed in by th	Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, s	treet, factory,	, office		2	8f. Location (8 City or Tox	Street a	and Number or te)	Rural Ro	oute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification:	(Check only 2 Medical Exami	sician: To the best of my kiner: On the basis of exam and manner stated.		nvestigation,	in my o	pinion, dea		ed at the time,	date a	nd place, and d	ue to the	e cause(s)
	To t To t	Σ	29b. Signature and little of certifier			29c.	License	number			29d. D.	ate signed (Mo	nth, Day	/, Year)
			1 (No				372	254			4	110	07	
	1541		30. Name and address of person who co											
1	Sta	ite	31. Date filed (Month Pay, Near) 200	D. 32: Registrar's Sig		MISLE	RI	RIVE	T(JWSON.	М	ARYLAN	D 2	1204

			For State Registrar	State of Mar		ertificate of		•	giene Reg. No. 2	7 11839
ì	Physici	an	1. Decedent's Name (First, Middle, Las Anola C. Wieland	st)				2. Date of De Month April	11, 200	3. Time of Death 11:00 P.M
	/Medic Examin		4a. Facility Name (If not institution, give Good Samaritan Ho			4b. City, Town, Balt	or Location of C imore		4c. County of	
.,	Funeral Director		5. Social Security Number 6. S 218-01-2195	ex 7. Age (In yrs. last birthday 87 Yrs.	Months Days		Hrs. 8. Date of Bin (Month, Date of Bin 1)	th Year 1919 M). Birthplace <i>(State or Foreign Country)</i> laryland
	Maryland a-f show ified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/		Oc. City, Town or I Baltimo					10d. Inside City Limits 1 → Yes 2 → No
	h with the 3a or 28a st be not	Funeral Director	10e. Street and Number 1601 E. Belvedere	Ave.		10f. Zip Code	21239		10g. Citizen of Who United S	•
036	be filed within 72 hours after death with the Maryland all Hygiene. An Hygiene. did they than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No		n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
9500-51212	d within 72 ho giene. rr than "natur the M. dical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Giv	edent's Usual Occu re kind of work done DO NOT use retir tral Gife	e during most of ed)		16b. Kind of Busin Hochshi Dept.	ld Cohn
Maryland		To Be C	17. Father's Name (<i>First, Middle, Last,</i> Albert Clasing)				Name (First, Middle ude Neal	, Maiden Surname)	
	s 1 and 2 should Health and Mer tem 27 Is marke other traumatic		19a. Informant's Name/Relationship (Joseph Teramani (ling Address (Stree Cottage		or Rural Route Numb TOWSON ,		ate, <i>Zip Code)</i> 21286
Baltimore,	6 0 -		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specit		20b. Place of Dis cemetery, ci Gardens	position (Name of ematory or other pl Of Faith	cen Ap	oril 16, 2007	20c. Location - Ci	ity or Town, State _e,Maryland
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer	f. jan						tion Gtr., P.A.
	Physician /Medical Examiner		23a. Pan 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Dilate	consequence of):	Ponew Homew	ving, such as ca	ardiac or respiratory a	arrest,	Approximate Interval Between Orset and Death LAS I have
8/60, 0		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Palen	consequence of): Lead if the consequence of):	Hus	con	·		Contraction of the contraction o
O. Box 68/	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 25 No 9 Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnan			23d. Date o	
rds, P.	iw requires that to be some the constant of th	by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause g	jiven in Part I.			ute to the cause of death?
Vital Hecords,	The law ate has b page 2 sl	Completed						24a. Was auto perf 1 Yes	ormed? dea	ere autopsy findings available or to completion of cause of ath?
VITA	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			ther:	f Death (Check only		
ō	Phy this ral d	7: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Inj	4 LI Nursi	ing Home 5 ☐ Res 28d. Describe	how injury occurred	
Division	or Attending Pafer death. Director: After in by the funera	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not b 4 Homicide determined			M 1[□Yes 2□No	28f. Location	(Street and Number wn, State)	or Rural Route Number,
	poital ours eral filled	Medical Ce	29a. Certifier (Check only one) Certifying Pl	nysician: To the best of miner: On the basis of e and manner state	xamination and/or	ath occurred at the investigation, in my	time, date and y opinion, death	place, and due to the occurred at the time	e cause(s) and mann , date and place, an	ner as stated. Id due to the cause(s)
)	To the Hos within 24 ho To the Fur completely	Me	29b. Signature and title of certifier	Tuy	prien		nse number 0661		29d. Date signed (April 12	
	3		30. Name and address of person who Sireesh Tripuarar				Blvd. I	Baltimore,	Maryland	1 21239
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	and a				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician М 0327 WOOD KEBECCA APRIL 8, 2007 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS HOSPITAL BALTIMORE CITY
If Under 1 Year | If Under 24 Hrs. JOHNS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2X F 214-21-6178 18 Director July 14,1988 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2¥ No Director Baltimore County Maryland Rosedale 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be rany injury or other traumatic event, the Medical Examiner must be rany 8304 Karol Avenue 21237 United States Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Puerto Rican Specify: Hispanic Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None Unemployed 12 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Wood Carmen Colorado ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carmen Zapata (Mother) 8304 Karol Avenue Rosedale, Maryland 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Oaklawn Cemetery April13,2007 Baltimore City 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 days EGENERATED MORTIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any setting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conse uence of Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending physic I for use as the b 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown SYNDROME Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation To the Hosping. Within 24 hours after death.

To the Funeral Director: Aft

--maletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19 th m.D. RES-000 APRIL 8 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHEA WOLFE Street BALTIMORE mo 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9866 4-27-07 yt. State of Maryland Poepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0 Yran **Physician** A Month 1 89 11:54a M Barbara Jean Wiley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PGSouthern MD Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12-12-1937 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs_last birthday) **Funeral** 1□M 2 F Days Hours Min Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location an "natural", or items 23a or 28a-f show Medical Examiner must be notified at MD PG Suitland 1¥ Yes 2 □ No Director 10f. Zip Code 20746 10g. Citizen of What Country? Street and Number USA 3901 Suitland Rd. #1215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 15 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes Ž No Specify: Baltimore, Maryland 21215-0036 Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Retail Sales Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Dermit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If Item 27 is marked other the any injury or other traumatic event, the Jones. the 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) John Wiley Ruthledge Pansy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3901 Suitland Rd #1215 Suitland, MD 20746 Sidney Jackson/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cem. 4-19-07 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Clinton, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facil Ronald Taylor II Funeral Hm 21. Signature of Funeral Service Licenses 108 W. North Ave., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ntarition **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a consequency of). Examine executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician certificate be Physician/Medical the as attending properties for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4□Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 ☐ Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş. 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2□ No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title pretider 29c. License number 29d. Date signed (Month, Day, Year) 200 mi) 10055120 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4

State

Registrar

310

Washington DC

Richard PALMERMO1328 Southern avenue JE

200

APR 13

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

			1 - For State Registrer	State of Maryla		artment of l			Reg. No.	7 11842
	Physici /Medi	cal	Decedent's Name (First, Middle, Last) Helen 4a. Facility Name (If not institution, give s	Hale Weed	1	4b. City, Town,	or Location o	2. Date of D Month	eath Day 4c. County	3. Time of Death
	Examir	ner	800 Southerly Road	street and manibery		Towson	or Location o	Death		Itimore
	Funeral Director		5. Social Security Number 6. Sex 220-18-6793	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of B Month, D July 5	irth Pay, Year) 1914	9. Birthplace (State or Foreign Country) Maryland
	ath with the Maryland 23e or 28e-f show ust be notified at	ector	10a. State 10b. County Maryland Baltimon		ity, Town or Lo					10d, Inside City Limits 1 □ Yes 2 □ No
	3e or 2	I Dir	10e. Street and Number 800 Southerly Road			10f. Zip Code	1286		10g. Citizen of	What Country? ISA
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23e or 28e-f show or other freumatic event, Itte Madical Examiner must be notified at	by Funer		12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cub		in? (Specify Yes or N , Puerto Rican, etc.)	o- 14. Rac Bla Specif	ce - American Indian, ck, White, etc. White
15-0	"netur	leted	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	pation during most	of working	16b. Kind of B	usiness/Industry
212	d within giene. ir than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		acher/Adr			Balt	imore County
Maryland 21215-0036	should be filed ind Mental Hygi s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) John Henry Hale					rs Name <i>(First, Middle</i> rie Estell		•
, Mar	1 and 2 sho Health and tem 27 is my		19a. Informant's Name/Relationship (Ty) William Hale	Nephew	2411	Parallel	Lane	· · · · · · · · · · · · · · · · · · ·	ing Mary	land 20904
Jore	Pages 1 nent of Hu int: If iter		20a. Method of Disposition 1 ☐ Burial ※XXCremation 3 ☐ R			sition (Name of matory or other pla		Date -		City or Town, State
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Innature of Funeral Service/License	and the same of th	en Mour	. Name and Addre	ess of Facilit		iedefeld	re, Maryland Funeral Home In land 21212
	Pnysician	11	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	ications that caused the deane cause on each line.		est 20 55	***************************************	among a spacetime to	arrest,	Approximate Interval Between Onset and Death
8760,	Medical Examiner ohysician and the prival-transit	edical Examiner	resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):		•	An 010	nscu	ntorn
.O. Box 6	the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnanc Other (specify)	у			te of delivery nnth Day Year
<u>a</u>	sign sign d be	by	Part II. Other significent conditions con	ntributing to death but not re	sulting in the ur	nderlying cause gr	ven in Part I.		tobacco use conf	ribute to the cause of death?
Vital Records,	The ate h page	Completed						24a. Wa. auto perf	opsy ormed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	Physicien: The this certificate al director, page	Be	25. Was case referred to medical examiner?	lospital:		Ott	hoe	of Death (Check only		
7	this aldi	ation: To	1 Yes 2 No ''' 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ry at		idence 6 🗆 Oth	er (Specify)
Division	iel or Attending P s after death. it Director: After ad in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Spec		eet, factory, office			(Street and Numb own, State)	per or Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physical Exemination (Check only one)	sicien: To the best of my kn ner: On the basis of examin and manner stated.	iowledge, death ation and/or inv	occurred at the ti restigation, in my	me, date and opinion, deati	place, and due to the h occurred at the time	cause(s) and ma , date and place,	anner as stated. and due to the cause(s)
	To the N within 24 To the P	Z	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month, Day, Year)
,			30. Name and address of person who col	moleted course of death (the	m 23a) (Tre-	8) 2	18	38	J U 451 C	7 200 /
	V		TOITH SIMALA	5ns n. n. s	18 CI	AMP M	13 AT)	nani 4	-191773	2109U 2109U 1000,00
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 200	32 Registrar's Sign	nature	ale				

State of Maryland / Department of Health and Mental Hygiene -Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:35 PM John Deyo Welte 3. 2007 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 601 Linwood Ave. Bel Air 8. Date of Birth (Month, Day, Yea If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1 XM 2 ☐ F Hours 406-50-4276 May 28, Director 66 1940 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir then "natural", or itsma 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 No Directo Harford Marvland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Linwood Avenue 21014 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 XYes 2 □ No 1 □ Never Married 2 □ Married 21215-0036 If Yes, Give Year or Dates: Vietnam 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then College (1-4or 5+) Hygiene. Elementary/Secondary (0-12) Dentist Dentistry Department of Health and Mental Hy, important: if Item 27 is marked other any injury or other traumatic eventance. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be Harry John Welte Elizabeth Jeannette Devo ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Little Lisa Lane, Spollville, GA 30078
ce of Disposition (Name of Date 20c. Location - City or Town, S Richard W. Welte/Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp 4-11-07 Towson, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P. A. (usse 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) motastance Physician quamous Curcinoma 5Kin months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical đ as IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Þ Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page this certificete 2□ No 1 Yes 2 No 1 Yes Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Yes 2- No 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: A hours after dea.

-rel Director; After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Hospital completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certified 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15484 0.7 30. Name and seess of person who completed cause of death (Item 23a) (Type, Print) 602 S. Atwood Road, Suite 200, Bel Air, MD 21014 Ashkan Bahrani, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** William Asa Walters 7:56 A April 9, 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Apt. A 1115 Vanquard Way Bel Air | Nonths | Days | Hours | Min. | S. Date of Birth | 9. Birthplace (State or Foreign (Month, Day, Year) | June 15, 1932 | Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** XXM 2□F Yrs. Director 74 248-66-3324 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location ehow. 10d. Inside City Limits r than "natural", or items 23a or 28a-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Bel Air Maryland | Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with USA 21015 1115 Vanquard Way Apt. A death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: Specify. ð 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) Consulting h and Mental Hygier 17 Is marked other ti 12 Computer Programer 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental Hitant: If Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) (nmn) Carter Walters Emma Thomas (nmn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 Bulls Lane, Joppa, MD 21085 Judy Tepper / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Depertment Important: If eny Injury o 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp! 4-12-07 Towson, Maryland 21. Signature of Fundral Service License 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf arteriosc **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiclen end for use as the burial-transit The law requires that the deeth certificate be executed Due to (or as a consequence of) Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. After this certificete has been signed by the tuneral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) to Yes 2 □ No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 Tes 2 No death М Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide after filled in To the Hospitel of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar

29b. Signature and title of certifie

30. Name and address of person -

DHMH 17 Rev 1/2001

MI DAE 16 31. Date filed (Month, Day, Yeal) APR 1 3 2007

completed cause of dea h (Item 23a) (Type, Print)

29c. License number

DOO 14206

1614 CHURCHVILLE Rd BEL AIR Md 21015

29d. Date signed (Month, Day, Year)

Registrar

State

ESSEX MEDICAL CTR

BALTIMORE, MD. 21221

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 13

MD

2: Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ΑM BARBARA ZEMO APRIL 9 2007 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day, **Funeral** 1 ☐ M 2 💢 F 07/27/1928 Director 78 NY 054-20-3518 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE REISTERSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 GLOUCESTER CT. 21136 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 💢 Married WHITE 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) REALTOR REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PHILIP KERZER ANNA STERN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9005 PADDOCK LANE, POTOMAC, MD ERIC COHEN / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State MOUNT LEBANON 04/11/2007 ISELIN, NJ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Tole 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ua to for se a consequence o Examiner law requires that the death certificate be executed 1200 attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed ∠4b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No
∠ 24a. Was an page 2 has autopsy perform certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 2 ER/Outpatient 3 DOA ٩ 1 | Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 ☐ Natural Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

2

Le 300,

29d. Date signed (Month. Dav. Year)

Dikesville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2007 2:25 P M Nancy Lee Allison March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Southern Maryland Hospital Prince Georges Clinton Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 219-48-3378 60 **Director** 1947 Mary Tand Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 □Yes XIX No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5902 31st Avenue Apt. 117 20782 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status l ∐ Yes 2∭ No f Yes, Give 1 Never Married 28 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No White ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Bus Aide Pr. Geo. Co. Government Pages 1 and 2 should be filed nent of Health and Mental Hygint: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Robert Boswell Thelma Lucille Goldsmith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Allison, Sr.-Husband 5404 St. Barnabas Rd., Oxon Hill, MD 20745 Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o once, 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gdns 3-30-2007 Waldorf, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00053 3035 Old Washington Rd. Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buna Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9∏Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy perform 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 Inpatient P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending After 5 Pending investigation 1 Natural thours after death.

uneral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the I 29b. Signature a 29c. License number Name and addre completed cause of death (Item 23a) (Type, Print) State MAR 3 0 Registrar

Physician
/Medical
Examiner
on Waterian House, 4
Funeral
Director
and the second s

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed burial-tra Records, P.O. Box 68760, as the use detached for the page 2 should has been Division or Vital Hospital or Attending Physician: ours after death.

leral Director; After this certifica filled in by the funeral director, I

ANDERSON

MABLE

To the Hospital within 24 hours a To the Funeral C Medical State Registrar

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 2007 Marion Mable Anderson 6:45 P M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) November 21, 1924 7. Age (In vrs. last birthday) Days Hours Min. 1□M 2 F 82 141-16-1379 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits St. Mary's Lexington Park Maryland 1 Yes 2 No Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 21559 Forest Run Drive 20653 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 1 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Bullard Harry M. Leaning 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Beby Martz / Daughter 21559 Forest Run Drive Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State April 5, 2007 Eglington Cemetery Clarksborough, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign fur of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): curdio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HyperLipidemis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No 1 npatient Certification: To 1 Tes 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062213 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sureshehai Patel, M.D. St. Mary Medical Arts Building Leonardtown, MD 20650 31. Date filed (Month Alex Year) 2 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:00 a M 27, 2007 March Bare Altieri 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days 1 □ M 2 😿 F 83 Yrs. 14, 1923 Tennessee 415-22-6077 Nov. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 🎗 🗆 No Maryland Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 USA 2512 McComas Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify:White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Coilege (1-4or 5+) Elementary/Secondary (0-12) C&P Telephone 12 Telephone Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Bare Dora Bare 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2512 McComas Avenue, Kensington, MD 20895 Christy Marie McDaniel/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State April 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3/27/07 Immediate Cause (Final disease or condition resulting in death) Ventricular Tachycardia Due to (or as a consequence of): unknown End-Stage Renal Disease Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of: Hyperkalemia lunknown Due to (or as a consequence of): Coronary Artery Disease unknown 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

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Vital

Division or

Physician

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mines have once.

Physician/Medical

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Certification: To

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Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1∐ Yes 2ဩNo 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

1 🔀 Inpatient 28a. Date of Injury (Month, Day Year)

Hospital:

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Pending investigation

6 ☐ Could not be

29c. License number D0062999 29d. Date signed (Month, Day, Year) March 27, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Petek Donmez, M.D. III19 Rockville Pike, #401, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year)

MAR 3 0 2007



24 hours a

Doris Anderson		State of Maryland / Department of For State Certificate Certificate			2007 1185
Physician Medical Examine	1	1 Decedent's Name (First, Middle,Last) DORIS ANDERSON		2. Date of Deat Month March 31 ,	h 3. Time of Death
	4	4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center	4b. City, Town, or Location Cheverly	on of Death	4c. County of Death Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 239 74 9924 1 M 2 F 61 Y	Months Days Ho	nder 24Hrs. 8. Date of Birt ours Min. JUNE 3	0 1945 Security) 9. Birthplace (State or Foreign Country) N • C •
d e.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local 10c. City, Town or	ation NDOVER HIL	LS	10d. Inside City Limits 1 XYes 2 No
with the Maryland is 23a or 28a-f shore notified at once in a fine of the individual of the individual Director	ין פרניס	10e Street and Number 7423 PARKWOOD STREET	10f. Zip Code 20784		Dg. Citizen of What Country?
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If the left is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.			Yes 2X No spec		14. Race - American Indian, Black, White, etc. Specify: BLACK
5-0036 ed within 72 hours after death lygiene. other than "natural", or iten the Medical Examiner must 1	nabidii	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Gi most of working life, DO No ERAGE ADMI)	OT use retired)	16b. Kind of Business/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	בי בי	17. Father's Name (First, Middle, Last) LEVI SMITH		her's Name (First, Middle, N DOROTHY LA	SSITER
y, MD 212; and 2 should be lealth and Menta ten 27 is marke traumatic event	1	ROBERT ANDERSON/HUSBAND 7423	PARKWOOD sition (Name of cemetery,	ST. LANDOV	iber, City or Town, State, Vir Cede) ER HILLS MD.
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: Ifficen 27 is marked other injury or other traumatic event, the Med To Re Comm		1 X Burial 2 Cremation 3 Removal from State HARMONY 4 Donation 5 Other Specify:	other place) MEM. PARK	4/7/07	LANDOVER, MD.
		3	435 14th S		ASH. DC. 20010
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line Immediate Cause (Final disease are consequence of): Due to (or as a consequence of):		is cardiac or respiratory arre	Between Onset and Death
,	1	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
0, be executed sician and burial - transit	LYall	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ob executed burial - transit	enica	MUNPENDED AMENDED #23a, 27, perME, g867, 5/	′15/07 TT		23d. Date of delivery
the death certificate by the attending phy ched for use as the business of the	1) SICIALIVIA	past 12 months?	etal death 3 Ecto Other (Specify)	opic pregnancy	Month Day Year
cords, P.O. Bo. law requires that the deal has been signed by the att 2 should be detached for a controlled by the Bhates	<u>≥</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in	1 Part I. 23e. Did to	bacco use contribute to the cause of death? 2 No 3 Probably 4 V Unknown
The Tage	nalaldilloo		20 Place of Da	24a. Was a autop perfor 1 Yes :	sy prior to completion of cause of med? death?
Vital hysician: this certification of the control of the certification	0	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatie	Othor		Residence 6 Other:
on of \ anding Physical After the funeral After	- 12	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 X Natural 5 Pending	f Injury 28c. Injury at W		now injury occurred
Division of Vital him 24 hours after death in 24 hours after death the Funeral Director: After this certifupletely filled in by the funeral director.	Certification.	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, str	eet, factory, office building	g, etc. 28f. Location (S or Town, S	Street and Number or Rural Route Number, City tate)
O the Hospital within 24 hours To the Funeral completely filled	ਰ	23a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.			
P 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	IME	29b. Signature and title of certifier	29c. License numb	ber	29d. Date signed (Month, Day, Year) April 2, 2007
Ju C	-	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street,	Baltimore, MD 21201	
Stat Registra	~	APR 1 (Month, Day Year) 32. Registrar's Signature		-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Michael George Bandik 23, 5:00 P M 2007 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M M 2 □ F 92 Director 579-14-1542 Nov. 22, 1914 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Director DC N/A Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1439 Whittier Place, N.W. 20012 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give 1943–46
Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2yrs Contract Inspector Metro 17. Father's Name (First, Middle, Last) unk. 18. Mother's Name (First, Middle, Maiden Surname) unk. Be ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1439 Whittier Pl., N.W. Washington, DC 20012 Margaret E. Bandik / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Crematory March 29, 2007 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licenses 7400 Georgia Ave., N.W. Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20057124 (men Bens, mi) 3/2910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Ctr. Dr.#201, Rockville, MD 20805 Truong Bao, MD 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar Mar30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1		State of Maryland /	Departme		Mental Hygi	() () ()	11852	
Physicia: /Medica	n	Decedent's Name (First, Middle, Last) ALMA WEBB BR	ISTOW			2. Date of Death Month APRIL 9	Day 2007	3. Time of Death 5:45A	
Examine	er	4a. Facility Name (If not institution, give str	LATA CENTER		, Town, or Location of Death LA PLATA or 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death		
Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last b	Months		(Month, Day,	Year) 9. Birth Con (place (State or Foreign intry) A	
death with the Maryland	ctor	10a. State 10b. County MD • CHARL		10d. Inside City Limits 1 ☐ Yes 2 ☐ No					
th with the 23a or 28	ai Director	10e. Street and Number #1 MAGNOLIA DR	IVE	10f. Z	ip Code 20646	10	g. Citizen of What Cou	untry?	
urs atter	by Funeral	11. Marital Status 12 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 XNo Specify:	pecify Yes or No- p Rican, etc.)	Black, White	ace - American Indian, ack, White, etc. ify: WHITE		
within 72 ho ene. then "netur	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)					ndustry	
d tai H	Be	9th 17. Father's Name (First, Middle, Last)			ne (First, Middle, M				
d 2 should th and Men 7 is marke traumatic	၉	JAMES S. WEBB 19a. Informant's Name/Relationship (Type		ss (Street and Number or Ru		lumber, City or Town, State, Zip Code)			
of Heel of Heel of Heel of Heel	1	MARJORIE CREWS 20a. Method of Disposition 1 Burial 2 Cremation 3 Re	moval from State 20b. Place cemet	of Disposition (N tery, crematory of	other place)	Date 2	0c. Location - City or	Town, State	
permit. Page Depertment Important: If any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	The state of the s	22. Name	REMATORY 4— and Address of Facility MOND FUNERAL	3070		VA.	
Physician /Medical		23a. Part1. Enier the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do cause or each line. Due to (or as a consequence	o not enter the m	PLATA, MD. 20 ade of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Under the bolivation of the conditions of the cause of the								
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e e e e	6	Part II. Other significant conditions cont	23e. Did tobacco use contribute to the cause of deat						
	Completed		perform 1□ Yes 3	autopsy performed? prior to completion of cause of death?					
rnysician: or this certifice and director, p	To Be	27. Manner of Death		Outpatient 3	26, Place of Dea Other: 4 Nursing H 28c. Injury at Work?	nce 6 Other (Specify)			
Attending Price death. ector: After the funeral by the funeral death.	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28f. Location (Street and Number or Rural Route Number,						
		29a. Certifying Physic	building, etc. (Specify) cian: To the best of my knowled or: On the basis of examination a				use(s) and manner as		
To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.	1 2	9c. License number	29	d. Date signed (Monti	h, Day, Year)	
3		30. Name and address of person who cor	nple cause of death (Item 23a	a) (Type, Print)	D0061652 50 Pembro	oke SB	, wan box	C, MD, 206	
Stat Registra		31. Date filed (Month, Day, Year) 2007	32. Registrar's Signature	Dane.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ivia	Cei	rtificate of I			Reg. No.2 0 0	/ 11854			
	Physicia		1. Decedent's Name (First, Middle, La Emma Charlotte					2. Date of Dea Month April	Day Yea	3. Time of Death 7 1:00 A M			
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death						4c. County of D	eath			
	Funeral			Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year	Avenue	8. Date of Birth	9.1	Birthplace (State or Foreign			
ı,	Director	}	224-46-4116 Usual Residence of Decedent	1□M 2⊠F	75 Yrs.	Months Days	Hours Min.	February		Country) Lrginia			
	yland now at		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits			
	ne Mar 8a-f sh otified	Director	Maryland St. Mar	ry's			enue			1 ☐Yes 2MNo			
	with the		10e. Street and Number 22739 St. Winifreds	Lane	•	10f. Zip Code	0609	'	10g. Citizen of What ' USA	Country?			
ဖွ	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	No I	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)					
Maryland 21215-0036	2 hours atural", cal Exa	ted by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine				
215	ithin 72 ne. nan "na	Completed	(Specify only highest gi	rade completed) College (1-4or 5	+)		during most of work f)	ing	Hospit	al			
d 21	Hygier Hygier ther th		17. Father's Name (First, Middle, Las	t)	l DI	etary Aid		e (First, Middle,	Maiden Surname)				
/lan	uld be Mental Irked o	To Be	Carroll Webster	Lumpkins			Nell	lie Cath	erine Wat	ts			
∥ar)	12 sho h and l 7 Is ma trauma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pachagal Cathoring Villians / Daughtor 22739 St. Vilnifrods Lang. Avenue MD 20609										
re,	f Healt item 2		Rachael Catherine Williams / Daughter 22739 St. Winifreds Lane Avenue, MD 20609 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State										
Baltimore,	Page ment o tant: If jury or		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Charles Memorial Gardens April 11, 2007 \ Leonardtown, Maryland										
Ball	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		21. Sign sure of Funeral Service Lice	Ladia	M P	.O. Box 270	ardiner Fun Leonardt	own. MD 2	20650				
30	Physician		23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)										
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of): HYGU a consequence of): Curd	-0:1444				> (42			
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	vithin To the compl	X	29b. Signature and title of certifier	Cit	<u>.</u>	29c. Licens	2213	2	29d. Date signed (M	onth, Day, Year)			
(Y,		30. Name and address of person who	o completed cause of d	eath (Item 23a) (Tyne	D: 0		M D	7 / 7 /	-			
_	, ,		22650 Cedar Lane Cou	ırt, Leonardto	own, MD 20650	Duresi	H. Patel,	r					
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	المنايين							

			4 101	epartment of Health and N Certificate of Death		giene 007	11855
			Decedent's Name (First, Middle, Last)		2. Date of Dea	ith	3. Time of Death
	Physici /Medio		LLOYD BROWN		Month MARCH	Day Year 29 2007	2:05A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
			CHARLOTTE HALL VETERANS HOME	CHARLOTTE HALL		ST. MAR	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day	h 9. B (, Year) (irthplace (State or Foreign Country)
	Director		578-52-1669 1929 2		OCT. 7	,1901 MI	SSOURI
	yiand Now		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
:	a-f si	ctor	MD ST. MARY'S CHARLOT	TE HALL			1 Yes 2四No
3	or 28	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What (Country?
	am w		37565 OAKS ROAD	20622		U.S.A	
	be filed within 72 hours after death with the maryland ital Hygiene. Ital Hygiene. do other than "neturel", or items 23a or 28a-f show event, the Madical Evanitier mail be notified at	y Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12 Yes, 2 No If Yes, Give	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify: 	ecify Yes or No- Rican, etc.)	Specify	nite, etc.
	urel',	d by	3 Widowed 4 □ Divorced Year or Dates: W . W . 1				WHITE
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	uld by Menta rked tic e	ToE	CLAUD BROWN	BIRDIE C	ROSS		
	and had is me		19a. Informant's Name/Relationship (Type, Print) 19b. N	failing Address (Street and Number or Rui	al Route Numbe	r, City or Town, State,	Zip Code)
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	rages need to hent of Hunt: If ite		1 Burial 2 Cremation 3 Bemoval from State	risposition (Name of crematory or other place) APRI	L2,	20c. Location - City of	
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	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre once.		21. Signature of Funeral Service Licensee M00641	22. Name and Address of Facility BRI 30195 THREE NOTCH R			
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Ŧ	mysician /Medical		Immediate Cause (Final disease or condition resulting in death)	JUMONARY 9	MBOL	1577	
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•	e exe ian ar urial-t		resulting in death) Last Due to (or as a consequence of				
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	w rec	Completed	Am AT FIREIN	ADIA	24a. Was a	an 24b. Were	autopsy findings available
	sicien: The law s certificate has b irector, page 2 s	mo		241190	autop	med? death?	completion of cause of es 2 \sum No
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	eath. or: A the fu	catl	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
	or Arr after d Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (S City or Tow	itreet and Number or i n, State)	Rural Route Number,
	to the hospite or Attending Prhysicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	al Ce	29a. Certifier Certifying Physicien: To the best of my knowledge,	death occurred at the time, date and place,	and due to the d	cause(s) and manner	as stated.
	in 24 in 24 ihe Fi pletel	ledical	(Check only one) Medicel Exeminer: On the basis of examination and and manner stated.				
1	To t	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)
11.	+1		1 US PLOWN	1)0056	152	5/31	301).
	00		30. Name and address of per in who completed cause of death (Item 23a) (T	_{ype, Print)} Road Prince Freder	rick Mar	rwland 206	78
9	/UY	ate		Noau filince fleder	ick, Fld.	Lyranu 200	, ,
	Registi		31. Date filed (Month, Day, APR 0 3 2007)	1 Anaths			

			For State	State of Marylan				nd Mental Hy	/giene	2007	11856		
			Registrar		Cei	rtificate of	Death	2. Date of D	Reg. No.	-001	3. Time of Death		
	Physici	an	Decedent's Name (First, Middle, Last) Tone	nie Cecelia Ba	1+a			Month APRI	Day	Year			
fanii H	/Medic	- 45	4a. Facility Name (If not institution, give s		атта	4b. City, Town, o	r Location of		1	2007 ounty of Death	5:40A M		
	EXCITION	E1	CIVISTA MEDICAL	CENTER		LAPLATA	Д		CE	IARLES			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2	Min (Month D	irth av Year)	9. Birthp	lace (State or Foreign		
sik	Director	9	220-20-8451	81 81	Yrs.	,		November	10,192	25 Maryla	and.		
	land t		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits		
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	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Coun	itry?		
	death with the Maryland rms 23a or 28a-f show r must be notified at		4140 Old Washington R			2060				USA			
	er deg	Funeral	Tr. Maria Salas	12. Was Decedent Ever in U. Armed Forces?	.S. 13.1	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0- 14	 Race - Americ Black, White, 			
30	rs aft I", or xamit	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 XX No	Specify:		S	Specify: Whit	e		
2-0036	be filed within 72 hours after death with the Marylar ttal Hyglene. do other than "natural", or Items 23a or 28a-f show other than matural", or Items 23a or 28a-f show the Medical Examiner must be notified at		15. Decedent's Educ		16a. Dece	dent's Usual Occup	oation	of working	16b. Kind	d of Business/Inc			
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and	be fill ntal H sd ott even	Be	17. Father's Name (First, Middle, Last)	C _{rr}				's Name (First, Middl		urname)			
5	2 should be f and Mental h Is marked of raumatic ever	은	Ernest Thomas Adams, 19a. Informant's Name/Relationship (Ty)		19b. Mailir	na Address (Street		y Henrietta . or Rural Route Num		City or Town, State, Zip Code)			
<u>8</u>	alth ar 27 is		Paul Robert Balta, Jr.		-I	,		goes, Maryla			,		
ē,	tem tem		20a. Method of Disposition	20b. F		osition (Name of matory or other pla		April Date	т	ation - City or To	own, State		
Ĕ	Pages nent of I ant: If its ary or o		1 Burial 2 □Cremation 3 □R 4 □Donation 5 □ Other (Specify)	emoval from State	James (_		10, 2007	Lexin	gton Park	, Maryland		
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Vital Records,	S b	Completed	PNEUMONIA 24a. Was a autops perfor						opsy formed?	24b. Were autopsy findings available prior to completion of cause of death? SNo 1 □ Yes 2 □ No			
Tan Tan		BeC	25. Was case referred to medical examiner?			- A		of Death (Check only					
o S	Sir b	To	1 ☐ Yes 2 🙀 No		ER/Outpatie	II 3 DOA		sing Home 5 Re			(y)		
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DIVISION	To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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1	V+V		30. Name and address of person who co	•									
	Sta	ato	ASHVIN PATEL 10 31. Date filed (Month, Day, Year)	2 PAUL MELI 32. Begistrar's Signa	ature		TE 1	J2 WALDO	RF,MD	20602	2793		
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** P^{M} DOROTHY MEARL BROWN 2007 10:15 MARCH 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 234-30-4740 85 **Director** 12, 1921 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 5425 Beall Drive 21704 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ⊠Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 🖾 No Specify \$ WWII 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edmond Mills Mearl Hale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Sylvia M. Brown / Daughter 5425 Beall Drive Frederick, Maryland 21704 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 5 West 1 Burial 2 □ Cremation 3 □ Removal from State 2007 4 ☐ Donation 5 ☐ Other (Specify) Baylous Cemetery Salt Rock, Virginia 22 Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Euneral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OBSTrucTive Pulmontry Disesse **Physician** /Medical Due to (or as a consequence of): Examiner NEUMONIA ASPINATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine PeripHern burial-trar Due to (or as a consequence of) attending physician Physician/Medical the asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2<mark>⊊</mark> No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000538

the Maryland

with

death v

72 hours after

Maryland 21215-0036

Baltimore,

certificate be executed

Box 68760,

P.O.

Records,

Division or Vital

State Registrar

Richard A. Silva, M.D. 9715 Medical Center Drive Rockville, Maryland 20850 31. Date filed (Month, Day, Year) APR 0 2 32. Pagistrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		-	For Stete Registrar	State of M	-	Departme <i>Certifica</i>			nd Me		ene g. No.	7	11058
			1. Decedent's Name (First, Middle, Last)						2.	Date of Death Month	Day	Yeer	3. Time of Death
	Physicia /Medic	_	Monnie	J. Brah	ce				М		31, 20		11:00P M
	Examin		4a. Facility Name (If not institution, give street and number)				ity, Town, or	Death		4c. County of Death			
			Glade Valley Nurs	ing Cent	er			sville			Fred		
	Funeral		5. Social Security Number 6. Sex	M 2□√F 7. A	ge (In yrs. last bin 91	Month	der 1 Year	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Year)	Cou	place (State or Foreign intry)
	Director		039-18-0842 1 Usual Residence of Decedent	X	91	Yrs.			J	uly 31,	, 1915	West	Virginia
	and	ŀ	10a. State 10b. County		10c. City, Town	n or Location							10d. Inside City Limits
	Maryian -f ehow lled al	ğ	Maryland Montgome	1957	C1a	rksburg	·						1 ☐ Yes 2 No
	the notified	ec ec	10e. Street and Number	L y	014.		Zip Code			10	g. Citizen of W	hat Cou	intry?
	3a o	<u>_</u>	13509 Clarksburg	Road			2087	1			U.S.	Α.	
	within 72 hours after death with the Maryland ene. than "returel", or iteme 23a or 28a-f ehow fra Marical Examinar must be notified at	Funeral Director	11. Marital Status 1	2. Was Decedent Armed Forces	Ever in U.S.	13. Was De	cedent of Hi	spanic Origin	in? (Specif	y Yes or No-		- Amer	ican Indian,
9	or its	2	1 Never Married 2 Married	1 Yes 2			2 XNo	Specify:	1 dento i no	an, oto.)	Specify		, etc.
21215-0036	ureli,	d b	3 XWidowed 4 ☐ Divorced	Year or Dates:		1	. 2.22.10					WI	ite
5-(72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	Decedent's U (Give kind of	work done a	luring most o	of working	1	6b. Kind of Bu	siness/l	ndustry
121	within then	g	Elementary/Secondary (0-12)	College (1-4or	5+)	`life. DO NO`	eacher	,			Public	Sch	1001
	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	47			1	18. Mother's	's Name (F	irst, Middle, M	laiden Sumam	e)	
Maryland	d be	9 Be	Ronald James					Н	ettie	Shinr	,		
$\overline{\mathbf{z}}$	Shoul nd Me mari	ပ	19a. Informant's Name/Relationship (Typ	oe, Print)	19b	. Mailing Addr	ess (Street a					State, Z	p Code)20838
N S	ath ar		Navada Pleasants -	Grandda	ighter	22610 (old Hu	ndred	Road	, Barne	esville	, Ma	ryland
ē,	S 1 a	Ì	20a. Method of Disposition		cemeter	Disposition (I	or other place	a)	Date	-	Oc. Location -	City or T	own, State
Ĕ	Page nt: # nry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Denation 5 ☐ Other (Specify)	emoval from State	Upper	Seneca	a Ceme	tery 4	4/4/0	7	Germant	own,	Maryland
3altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Introportant: if item 27 is marked other than "neturel; or iteme 23a or 28a-f ehow introportant: if item 27 is marked other than "neturel; or iteme 23a or 28a-f ehow any injury or other traumatic event, it is Marical Examinat must be notified at once.	Ì	21. Signature of Funeral Service Dicense	·) (· , .)		and Addres		iame	DΛī	Superal	Hon	10
Ω	89 = 8		Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872										
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Physician		Immediate Cause (Final disease or condition									Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):							you
	Examine	_	Sequentially list conditions, b.		a consequence	-0							
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Вох	death certific e ettending p od for use as	N/N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregnancy 2 Petal death	205					23d. Date	of deli	very
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H		Co	10							perform 1 ☐ Yes 2	1	eath?	2 No
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Division	Atten r deal ctor: y the	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ir	ijury - At home, fa	ırm, street, fac	tory, office		281	Location (Str	eet and Numb	er or Ru	ral Route Number,
Ö	after Direction	Certification:	4 Homicide	building, e	tc. (Specify)					City or Town	, State)		
	ospit hours unera iy fille		29a. Certifier 1 Certifying Phys	icien: To the bes	t of my knowledge	e, death occur	red at the tim	ne, date and	place, and	d due to the ca	use(s) and ma	nner as	stated.
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	one)	and manner s	tated.				Demined				
	To To	2	29b. Signature and title of dertifier				29c. License	number	. /	29	d. Date signed		
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,	8		30. Name and address of person who co	•			anuc	Frode	riole	Moral	and		
			Allen J. Gilson N 31. Date filed (Month, Day, Year)		1475 Ta	illey AV	enue,	rrede	LICK	, maryl	and		
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:30P M 2007 Jessie Bell March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🕅 F 84 South Carolina Director 577-28-8401 July 4, 1922 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 TXYes 2 □ No Director Prince George's Maryland Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 620 Sheridan St., #519 20783 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: **Black** 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th Sterile Supply Technician Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Felder Mary (Unknown) ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Sheridan St., #519, Hyattsville, MD of Disposition (Name of Date 20c. Location - City or 1 20783 William Bell/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lee Crematory 422. Name and Address of Facility 4-4-07 Clinton, Maryland 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock on heart failure. List only one cause on each line. Mys carely Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day signed by the and be detached for 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed' To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard Palmer M) 1328 Southern W 1328 Souther avenue SE Suite 310 Washington DC Zerr32 32. Registrar's Sign

(Check only one)

31. Date filed (Month,

29b. Signature and title of contified

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0055120

29d. Date signed (Month, Day, Year)

Mar 25, WUT

	1 - For State Registrar			Ce	rtificate of l	Death	1	Reg. No.	(111)	With the second
an	Decedent's Name (First, M.	iddle, Last)					2. Date of De Month	eath Day	Year	3. Time of
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er	4a. Facility Name (If not institu	ution, give street ar	nd number)		4b. City, Town, or	Location of Death		4c.	County of Deat	th
	Hillhaven Nu				Ade 1	phi If Under 24 Hrs.	8. Date of Bi			eorge's
	5. Social Security Number	6. Sex 1 ☐ M 2 ☐	3xF	s. last birthday) Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	Co	thplace (State o
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	10a. State 10b. Cou		10c. C	City, Town or L	ocation					10d. Inside Ci
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Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	ountry?
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Funeral	11. Marital Status		s Decedent Ever in red Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No	0- 1	14. Race - Ame Black, Whit	
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	17. Father's Name (First, Mide	Idle (act)			Homemaker	18. Mother's Nam	ne /First Middle	Maiden	Own Hor	me
Be							•		<i></i>	
2	Conley Phili 19a. Informant's Name/Relati		ne)	10b Maili	ing Address (Street a		Hounshe		r Town State	Zin Code)
	Doris Mary Foo				12 01d Co					
100	20a. Method of Disposition	mier, er		_	osition (Name of	Tumbia P.	Date Du	_	cation - City or	
	1 Eurial 2 ☐ Cremati		I from State	cemetery, cre	matory or other place	tery np.	ril 3		·	
	' 4 ☐ Donation 5 ☐ Othe 21. Signature of Funeral Sen					2				, Maryl
	21. Signature of Furieral Serv	VICE LICENSES	0		Flamensdog					
	23a. Part1. En er the disease	s or complications	that cause the de		500 Unive				er Sprii	ng, MD Approximat
	shock, or *eart failure.	List only one caus	e on each line.	atri. Do not en	itel the mode or dyin	g, such as cardiac	or respiratory i	arroat,		Interval Bet Onset and I
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ciar	1 ☐ Yes 2 🗷 No 9 ☐ Unknown		Unknown							
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 7

	1	For State Registrar	State of	Maryla				ealth a Death		Re	g. No.	The state of the s		
Physician		 Decedent's Name (First, Middle, Dewitt 	Hous!	on	Ra	ker				Date of Death	Day	Year	3. Time	_
/Medical		4a. Facility Name (If not institution,			Da		Town or	Location of		irch 28,	4c. Count	v of Death		
Examiner		Prince George's Ho	_	017		40. 0119	Cheve		Doain		Prince			
Funeral			6. Sex 7.	Age (In yrs	. last birthday)		r 1 Year	If Under 2	24 Hrs. 8.	Date of Birth (Month, Day,	1	-	place (State intry)	or For
lirector		246-22-7409 Usual Residence of Decedent	1 反 M 2□F	82	Yrs.	Months	Days	Hours		cember				
show ide		10a. State 10b. County	a 1		city, Town or Lo per Marlk								10d. Inside	City Lir
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Die I	5	10105 Prince Pl.,	¥201			207	Code			10	g. Citizen of U.S.		intry?	
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by by	2	1 ☐ Never Married 2 ☐ Marrie 3 🖔 Widowed 4 ☐ Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	⊠No	1			n, Mexican, Specify:	, Puerto Ric	an, etc.)			, etc. rerican	Į
ygiene. ner than "natura it, the Wedical I		15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usu	al Occupa	ation Juring most	of working	1	6b. Kind of B	Business/I	ndustry	
npid m	-	Elementary/Secondary (0-12)	College (1-4	or 5+)	1)	of working		Constru	ction		
ont, the	5 -	12th			Truc	c Driv	er –							
marked oth marked oth umatic even	2 -	17. Father's Name (First, Middle, L Houston Glenn			_			Pear	l Baker					
7 is m raum	ĺ	19a. Informant's Name/Relationsh								oute Number,			p Code)	
Healt em 2 thsr i		Shirley A. McCullour 20a. Method of Disposition	n-Daughter	20b.					Upper M	arlboro,	MD 207 0c. Location		own State	
Depertment of Health and Importent: If them 27 is n any injury or other traun once.		1 XBurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp			Place of Dispo cemetery, creaty ryland No.	ationa	l_		4–7–07	I	aurl, M	aryla	nd	
any in		21. Signature of Funeral Service L	. Lun	_/	25	Name a 28	nd Addres th St.	s ol Facility	Barnett , WDC 2	ne & Assa 20018	c. Fune	ral H	ome Inc	•
physician and street sthe burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a conse			\$10 h man of the 10 miles							
igned by the attending physical for use as the be detached for use as the by Physician/Medic		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	1 2 ☐ Fet t at time of	el déath 3[Ectopic p Other (sp						ate of delive	very Day	Year
5 8		Part II. Other significant condition	as contributing to deat	h but not re	sulting in the u	nderlying o	ause give	in in Part I.		23e. Did toba	acco use con			
within the form of	-	un								24a. Was an autopsy perform	ed?	Were aut prior to co death? 1 🗌 Yes	opsy finding ompletion of 2 \(\text{No} \)	s avai
rector	11	25. Was case referred to medical examiner?	Hospital:				Othe			heck only one				
After this c funeral dire	-	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigs	28a. Date of I (Month,		28b. Time of Injury		28c. Injury Work	at	28d	5 Resider			ify)	
within 24 hours after dearn. To the Funeral Director: After t completely filled in by the funeral Medical Certification;		2 Accident Investigated Accident Could not determine	ot be 28e. Place of	Injury - At I etc. (Spec	nome, larm, str ify)					Location (Str. City or Town,		ber or Rui	al Route Nu	mber,
thin 24 hours the Funeral mpletely filled Medical C		29a. Certifier 1 Certifying (Check only 2 Medical)	Physicien: To the be xaminer: On the basis	s ol examın	owledge, deatl ation and/or in	n occurred vestigation	at the tim	e, date and inion, death	d place, and h occurred a	due to the car at the time, da	use(s) and m te and place,	anner as	stated. to the cause	u(s)
Me Me		29b. Signature and it sor certifier		statou.		29	c. License	number		29	d. Date signe	d (Month	Day, Year)	
		+ 411)			D5	520	20		3-	30	-07	1
		30. Name and address of person w	TIN	death (Ite	m 23a) (Type, HOSA				L	HEVE	RLY, 1	MD	201	85
× State		31. Date liled (Month, Day, Year) APR 0 2 2007	32. Reg	strar's Sign	all A						7			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Q15 A M ennis Beaghan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Annaul Medical Massort Anna Cent if Under 1 Year | if Under 24 Hrs. 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Days Hours Months 382-64-2655 Michigan 50 10,1956 Director Nov. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1XYes 2 □ No injury or other traumatic event, the Medical Examiner must be notified Directo MD Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 20716 USA 3212 Norshire Terrace or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours atter to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or item any injury or other traumont. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 →No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Distributor Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Catherine Warren Casper P. Beaghan ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowie, MD. 20716 3212 Norshire Terrace Julie B. Beaghan / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 04/03/2007 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD. 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 20715 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed sician and burial-trans Due to (or as a consequence of): cate has been signed by the attending physician, page 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2▼No 24a. Was an autopsy pertorm 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 은 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 29, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd Sute 300 Annapolis 9W 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State APR 02 2007 Registrar

			For State Registrar	State of	Marylan		artmen				lental Hyg	jiene eg. No. 2		11864
(g) ²			1. Decedent's Name (First, Middl	e, Last)							2. Date of Dea		V	3. Time of Death
•	Physicia /Medic		Donna J. E	arron							March	29	2007	9:17 A M
	Examin		4a. Facility Name (If not institution	n, give street and numb	er)		4b. City,	Town, or	Location of	of Death		4c. Cc	ounty of Death	
		e se ^{go}	Gilchrist Cen	ter for Ho	spice	Care		To	wson			E	Baltimo:	re
₹¥.	Funeral Director		5. Social Security Number 454–84–6847	6. Sex 1 □ M 2 ☐ F	Age (In yrs. 58	/ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Nov • 12	, Year) ,1948	Coui	place (State or Foreign ntry) Siana
1500	and w		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	f sho	ō		ester		Ocean	City							1 XYes 2 No
	the N	Director	10e. Street and Number	CSCCI		Occan	10f. Zip				1	Og. Citizer	n of What Cou	ntry?
	with Ba or t be	Ö	215 South Ocea	n Drive				218	42				USA	
	feath	Funeral	11. Marital Status	10 Mas Deced	ent Ever in U	.S. 13.	Was Deced			igin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Americ	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Mar 3 Widowed 4 Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	V No		If Yes, spec		n, Mexicar Specify:		Rican, etc.)	sı	Black, White, pecify: Wh	etc. ite
0	72 ho natur ical	Completed		t's Education st grade completed)		16a. Dece	dent's Usua	al Occupa	ation	t of worki	ina	16b. Kind	of Business/In	dustry
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	filed within Hygiene. other than sent, the M	5		2		Vice	Pres.	Mic					tality	
Maryland	tal Hid oth	Be	17. Father's Name (First, Middle,								(First, Middle,		irname)	
yla	should be fund Mental I marked of umatic eve	၉	Donald A. Bar								C. Lamb			
<u>a</u> r	2 sho and is ma		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numbe	r, City or T	own, State, Zij	o Code)
	1 and 2 Health tem 27 l		Sharon L. Damer	on / Compa			Colo		ke Dr		Severn,	MD.	21144	Otata
ore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from St		Place of Dispo cemetery, cre	matory or o	ne of other plac	e)	·	Date	20c. Loca	tion - City or T	own, State
Ë	men men tant: jury		4 □ Donation 5 □ Other (5		Ft.	Linco					/2007	Brent	wood,	MD
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Euneral Service	Licensee	0.0	2	2. Name an	d Addres	s of Facilit	ity Be	eall Fun	eral		
_	= 4 O		bu	en low	علا		512 N			-	Bowie		207	
	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. OVA	the dear	J CA					cetast		S	Approximate Interval Between Onset and Death
May the	Examiner		Sequentially list conditions,	b										_
	D #	Examiner	if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	Due to (or	as a consec	quence of):								
	ecute and -trans	am	that initiated events resulting in death) Last	C. Due to (or	as a consec	allence of).								
3760,	cian cian curial		,	Due to (or	as a consec	quenos ory.								
87	cate I physi the t	dical		d										
O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		h 2□Feta nt at time of o	al death 3[⊒Ectopic pi ⊒ Other (sp					230	d. Date of deliv Month	ery Day Year
P.0	that tl		Part II. Other significant conditi	ons contributing to dea	th but not res	sulting in the u	ınderlying c	ause give	en in Part I	1.	23e. Did to	bacco use	contribute to t	the cause of death?
Records,	signé d be	d by	Acute cen	chrovasc	ular	acey	deet	St	rok	e	1 □ Y	es 2□	No 3 ☐ Pro	bably 4 Unknown
Ö	w requir been si should	Completed	huner coass	uch lite	20	nnu	24	car	691		24a. Was a	an	24h Were aut	opsy findings available
Rec	has has	d m	right addig	andiana	2 1	1					autop	sv	pnor to co	ompletion of cause of
<u></u>	certificate ector, pag		werenas o	celusia	21.18m	Troc						med? 2X No	1 ☐ Yes	2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hoenital:		JED/0-4#-	-1 00 00	Oth	ar.		h (Check only or		A	un Dicc
ŏ	ding Physician: The lav n. After this certificate has funeral director, page 2	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatie		28c. Injur Worl	4 ∐ Ni	r	me 5 Resid			TY) HOSPICE
on	ding h. Afte fune	tion	1 Natural 5 ☐ Pendi		Day Year)	Injury	М		k? Yes 2 □					
Division	Attending r death. ector: After by the funer	fical	3 Suicide 6 Could	not be 28e. Place o	f injury - At h	jome, farm, st	reet, factor						Number or Rui	ral Route Number,
Div	after after Dire	Certification:	4 ☐ Homicide deterr	building	g, etc. <i>(Speci</i>	ify)					City or Tow	n, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		ng Physician: To the base and manner	is of examin									
	To th withir To th comp	Me	29b. Signature and title of certific		A 4		29	c. Licens	e number			29d. Date	signed (Month	, Day, Year)
			Dendol	RICHA	ell	us	4	79	564	43		03/	29/2	207
R	(10)		30. Name and address of person	who completed cause	of death (Ite		, Print)	tew	~B	lud,	/Bacto	Mì	212	.04
'	Sta	ate	31. Date filed (Month, Day, Year	32/Re	gistrar's Sign	ature	<u>_</u>			1				

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:45 AM 2007 Bailey aka Florence H. Bailey Mar. 28 Katie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Woodside Center Nursing Home Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months 1 ☐ M 2 🖾 F 579-48-1174 88 May 29, 1918 Virginia Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County r 28a-f show notified at 1X Yes 2 □ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or Items 23a or Examiner must be 20017 USA 1200 Upshur St. N.E. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married r than "natural", or I the Merical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Domestic Work Self Employed filed marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fil Health and Mental H tem 27 Is marked otl Roxie Taylor Les Haynes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 Is any injury or other trau Washington, DC 20017 Arthur Marshall/Cousin 1200 Upshur St NE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation 3 Removal from State 4-2-2007 Brentwood, MD. 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 22. Name and Address of Facility Marshall's Funeral Home 21, Signature of Funeral Service Licenses marshal 4217 9th. St. N.W. Washington, D.C. 20011 23a. Paki. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Severe Pulmonary Hypertension /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the I esn 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No P.0. the detached 9□Unknown 9 Unknown à signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an Staghorn Renal Stones has page 2: autopsy nerform Left Heel pressure ulcer 1 Yes 2 No Division or Vital Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: death. 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. nunletely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Day mo D0058965 March 29, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saima U. Khawaja, MD 11119 Rockville Pike Ste 100 Rockville Rockville, MD. 20852 32. Registrar's Signature 31. Date filed (Month, Day, Year)

MAR 3 0 2007 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#26. PerPhys. PGC3-30-07cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Yea **Physician** 2846 PM March 200 George M. Biggers /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's

9. Birthplace (State or Foreign Country) #203 9126 Edmonston Terr., Greenbelt
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Months Days 1<u>X</u> M 2□ F Director 577-38-0597 11, 1932 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 TyYes 2 No Prince George's Funeral Director Maryland Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9126 Edmonston Terrace, #203 20770 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Ind 11. Marital Status Black, White, etc. 1 □Xes 2 □ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 □tNo 5-0036 Specify: Specify: **Black** Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) National Distributors Private 12th Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 Is marked o Will Biggers ဥ Mary Mitchem 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Rivers/Friend 9126 Edmonston Terr. #203, Greenbelt, MD f Disposition (Name of Date 20c. Location - City or Town, Sta 20770 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any injury or o 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Qonation 5 □ Other (Specify) Harmony Memorial Park 4/2/2007 Landover, MD 22. Name and Address of Facility 21. Sign nure of Funeral Service Lic os Stewart Funeral Home 4001 Benning Rd., NE Wash. DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a conseque see of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a gone quence Physician/Medical Examiner requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month ρ Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a a linknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 45 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1□ Yes 2 1 certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 300A P After this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury at Work? Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar

J. HONG 75 Main Street. 31. Date filed (Month, Day, Year) 32. Registrar's Signal 3 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

title of certifier

29b. Signa

the

2

29c. License number

29d. Date signed (Month, Day, Year)

Laurel,

			_ For	State of Marylan	d / Depa	artment of	Health an	d Mental Hy	/giene)		
			1 - State Registrar		Cei	rtificate of	Death		Reg. No	2007	W 170 J. W	867
	Physici	an	1. Decedent's Name (First, Middle, La	,				2. Date of D Month		yYear	3. Time o	
	/Medic		Michael Cocchiaro					March			6:15	A M
	Examin	er	4a. Facility Name (If not Institution, giv	e street and number)		Lanham	or Location of D	eath		County of Death		
100	Funeral		Magnolia Center 5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year			irth	9. Birth	place (State	or Foreign
	Director		577-03-8585	X M 2□F 89	Yrs.	Months Days	Hours N	Min. (Month, D May 2	, 191	7 West	intry) Virgi r	nia
Т	pur "		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	ocation					10d, Inside C	ity Limits
	Maryla f sho	ō			densbu							2 □ No
	28a-	Directo	Maryland Prince G	eorge s bra	densbu	10f. Zip Code			10g. Cit	izen of What Cou	intry?	
	h with		5405 Tilden Road			20710			USA			
	ems ser un	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin' ban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Ameri Black, White		
20	or it	by Fu	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1XXves 2 □ No If Yes, Give		1 □ Yes 2 X No		,		Specify:		
3-003p	be filed within 72 hours after death with the Maryland Hygliene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		15. Decedent's E	Year or Dates:	16a. Dece	dent's Usual Occu	upation		16b. K	Whj ind of Business/Ir		
<u>5</u>	hin 72 e. In "ne Medic	plet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	e during most of ed)	working	Ī			
7	ed with	Completed	8		Cab D	river			Se1	f Employ	/ed	
and	be file	Be	17. Father's Name (First, Middle, Last	")			l .	Name (First, Middle		•		
<u> </u>	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	우	Paul Cocchiaro	(Trans Palest)	405 14-18	Add (Ot	-	a Bongiov				
<u> </u>			19a. Informant's Name/Relationship (James M. Cocchian					r Rural Route Num Bowie, M	_		p Coae)	
คั	es 1 and of Health fitem 27 r other tu		20a. Method of Disposition	20b. F		osition (Name of matory or other pl		Date		ocation - City or T	own, State	
Баппто	permit. Pages Department of Important: If it any Injury or o once.		14 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Theilioval Itolii State			t	/30/2007	Bren	twood. N	MD	
a	permit. Departn Importa any Inju		21. Signature of Tuneral Service Lice		2:	2. Name and Addr	ress of Facility R	obert E.	Evan	s Funera	al Home	2
	20 E # 9		FIG					Road Bow		D 20715		
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	pplications that caused the deat one cause on each line.	h. Do not ent	ter the mode of dy	ing, such as car	diac or respiratory	arrest,		Approxima Interval Be Onset and	te tween Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	.a. Cerebrilles		UHCO	n				Syr	~/
	Examiner			Alake ne	uence of):						300	_
	v 41.	Jer	Sequentially list conditions,	b. Que to (or as a donseo	uanoc of):						7	
	ecuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Concer of	of Co	lar					59V	~ '
Ď,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conse	uence of):						Con Cons	<u> </u>
09/90	physicate l	dical		d. Hypert	us						iogr	- 1
XOD	certiff nding Jse as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna						23d. Date of deliv	verv	
<u> </u>	death e attel d for u	iciai	in the past 12 months?	1□Live birth 2□Feta 4□Pregnant at time of d		⊒Ectopic pregnan ⊒ Other <i>(specify)</i> .	су			Month		Year
5	at the by the tache	Physician/Med	9 □ Unknown	9∐Unknown								
<u>'</u>	w requires that the death certificate been signed by the attending phys should be detached for use as the	by F	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.			use contribute to	V	,
coras,	requi	sted						. 8		□ No 3 □ Pro	boably 4 po	Unknown
d)	e law has b je 2 sh	Completed						24a. Wa	s an opsy formed?	24b. Were aut prior to co death?	opsy findings ompletion of o	available ause of
	n: The ficate har, page		OF Mice case referred to medical					1□ Yes	2 No		2□ No	
NEW NEW	ding Physician: The lav n. After this certificate has funeral director, page 2 a	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	at 30 004 Of		Death (Check only ng Home 5 ☐ Res		6 Dother (C	:4.1	
0	g Phy er this eral d		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe			uy)	
SION	Attending r death. ector: After by the funer	atio	Natural 5 Pending 2 Accident investigatio	n	injury		Yes 2 No					
<u> </u>	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, str	reet, factory, office	Э		(Street ar own, State	nd Number or Rui e)	ral Route Nur	nber,
2	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur		29a. Certifier Certifying Pl	hysician: To the best of my kno	wiladas dast	h coourred at the	time data and a	loge and due to the		\d	_t_td	
	24 ho 24 ho Fun etely i	edical	(Check only one)	miner: On the basis of examination and manner stated.	ation and/or in	ivestigation, in my	opinion, death	occurred at the time	e cause(s e, date an	d place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of pertifier				nse number			te signed (Month		
ı			- au			DO	03472	2	3-	-28-	100)	7
1	XX		30 Name and address of person who	· ·								
301	V \		Vicken Poochikia 31. Date filed (Month, Day, Year)	n, M.D. 5632 Registrar's Signa		lis Road	Bladens	sburg, MD	207	10		
	Sta Registr		MAD 9 Q 20		e L	30 M 6						

Director show be filed within 72 hours after death with altimore, Maryland 21215-0036

'natural', or items 23a or 28a-f shov dical Examiner must be notified at traumatic event, the Medical

at Hygiene. and Mental Department of Health a Important: If item 27 is any injury or other tra once,

Examiner The law requires that the death certificate be executed use as the burial-trar aftending physician for use as the huria been signed by the s should be detached page 2 certificate or Attending Physician: director this funeral After death. the Director:

P.O. Box 68760,

Division or Vital Records,

filled in by within 24 hours a

To the Funeral I

completely filled To the Hospital 15 State Registrar

Ray, E, Coffman

4a. Facility Name (If not institution, give street and number) 2007 23 4c. County of Death Examiner Univ. of Maryland Medical Centur Baltimore NIA If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 9/1/1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Days 1X M 2 □ F 220-18-7899 82 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Funeral Director MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4201 South Hunter Road 21074 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Yes 2 XNo Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier Post Office 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Everett Dewey coffman Ruth Elizabeth Franklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Blanche Coffman - Wife 4201 South Hunter Road Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem U.M. Cemetery 3/26/2007 Hampstead Maryland 22. Name and Address of Facility Eline Funeral Home 934 South 21. Signature of Funeral Service Licensee M001490 Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): 2 months Vecrotizing Fasciitis
Due to (or as a conse Pence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metastatic Prostate Cancer 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Atrial Frontlastin 2□ No 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural Injury

29b. Signature and title of certifier Item 23a) (Type, Print) 30. Name and address of person who completed cause of d

29c. License number

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

P21207

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

23, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Reg. No.

11:50

1 ☐ Yes 2 XNo

Approximate Interval Between Onset and Death

month

Year

Yolanda M. Lenzy, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

MAR 2

Could not be

determined

Green Street, 32. Registrar's Signature

College (1-4or 5+)

15. Decedent's Education (Specify only highest grade completed)

Annunzio DelMastro

1X Burial 2 ☐ Cremation 3 ☐ Removal from State

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

Marie Pavlides/daughter

Specify: White 16b. Kind of Business/Industry

Homemaker

Myocurdeal

(Give kind of work done during most of working life. DO NOT use retired)

16a. Decedent's Usual Occupation

12229 Heathcliff Ct. Ellicott City, Md. 21042

20b. Place of Disposition (Name of cemetery, crematory or other place) 4-3-2007 3/3/2007-Crest Lawn Memorial

22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043

mound 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

Completed

Be

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

29a. Certifier

Physician

/Medical

Examiner

burial-trar and

signed by the attending physician d be detached for use as the buria

funeral director,

After t

the

e Hospital or Attending P 24 hours after death. e Funeral Director: After t

Division or Vital Records, P.O. Box 68760,

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9 I Inknown

3 ☐ Ectopic pregnancy 5 Other (specify)

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

act but for heunatoul

a meurosii

24a. Was an

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

2 Accident 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number 1722443

30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print)

4801 Dersey Hall Dr = 226 Ellicoff City Gertler

State Registrar

DHMH 17 Rev 1/2001

2. Date of Death Month March

2/27/1921

29

3. Time of Death 8:52 p_M

2007

4c. County of Death

Howard 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)

Connecticut

10d. Inside City Limits

1 □Yes 2 No

10g. Citizen of What Country?

USA Race - American Indian, Black, White, etc.

Home.

18. Mother's Name (First, Middle, Maiden Surname)

Rachel Congiano

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20c. Location - City or Town, State

Marriottsville, Md.

Approximate Interval Between Onset and Death

23d. Date of delivery

Dav

23e. Did tobacco use contribute to the cause of death?

Year

1 Yes 2 No 3 Probably 4 Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dewey Chapman 12:43 AM March 28 7007 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Medical Tystem Baltimore City Baltshore If Under 1 Year | If Under 24 Hrs. 3. Date of Birth (Month, Day, Year) 03/04/1957 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Months Days **X**M 2□ F Hours 50 577-76-2339 Washington, DC dence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Forestville YXYes 2 □ No PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3612 Key Turn Street 20747 U.S.A. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Maintenance Engineer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Essie Weaver Althea Alexander Chapman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3612 Key Turn Street; Forestville, MD Patsy M. Chapman - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/03/2007 Landover, Maryland Harmony Memorial Pk. 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licenses Kendany ruman 4594 Beech Road; Temple Hill, MD 20748 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aml Due to (or as a consequence of): Respirator distress Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform

Physician /Medical Examiner

Examiner

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show ner must be notified at

Examiner must

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'natural", er than "nature the Medical E

marked other

27 is r

Department of Health Important: If item 27 any Injury or other to

traumatic

t and 2 should be Health and Mental

Pages 1

Director

Funeral

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Completed

Be

MD

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

requires that the death certificate be executed burial-trar physician the attending ph for use as tl ed by the a detached f signed I page 2 should peen certificate Physician: this After or Attending

Division or Vital Records, P.O. Box 68760,

Physician/Medical Completed by funeral director, Be Certification: To 24 hours after deatl Funeral Director; filled in by

Hepatitis C 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 ☐ Accident Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one)



Hospital

death

State Registrar

Medical

M.D.

AU4176435416662

29c. License number

29d. Date signed (Month, Day, Year) March 28,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene St. Baltomore. HUR 21201

31. Date filed (Month, Day, Year MAR 2 9 2007

29b. Signature and title of certifier



			1 - For State Registrar	State of Maryla		artmen rtificate			nd Men		giene Reg. No.	2007	1 67
\$1	Physic		1. Decedent's Name (First, Middle, Las Mabel Chasten	st)					_ N	Date of De Month rch	ath 28	2007	3. Time of Death 6:00 a M
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of		.1 011		County of Death	
N. C.		<i>∰</i>	Manor Care Nursi				argo				Pr	ince Ge	orge's
Ы	Funeral		5. Social Security Number 6. S	□M 2√2 F	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2- Hours	Min. (Date of Birl Month, Da	y, Year)	Cou	place (State or Foreign intry)
2	Director		245-18-1724 Usual Residence of Decedent	}	37				3	/20/1	920	Nort	h Carolina
	how how		10a. State 10b. County		City, Town or Lo								10d. Inside City Limits
	Ba-1 s	Director	Maryland Prince Ge	eorge's	Camp	Spring	gs						1⊠Yes 2□No
	with th	Dire	10e. Street and Number			10f. Żip					-	en of What Cou	intry?
	eath ve 23	erai	5243 Kenstan Driv	7e 12. Was Decedent Ever in	11 9 13	Was Doord		20748	in? (Specify)	Vac or No	US	A 4. Race - Ameri	inan Indian
036	be filed within 72 hours after death with the Maryland stal hygiene. Id other than "natural", or Iteme 23a or 28a-1 show event, the Medical Exacting must be notified at	by Funeral	1 Never Married 2 Marned 3 ∰Widowed 4 Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	į	If Yes, spec			in? (Specify Puerto Ricar	n, etc.)		Black, White	
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)		dent's Usua kind of wor			of working		16b. Kir	id of Business/Ir	ndustry
21	han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)	oring most	or working			n and W	
2	filed wit Hygien Sther th	S	12 17. Father's Name (First, Middle, Last)		Lá	aborer		19 Mothod	's Name (Fir			cco Fact	cory
altimore, Maryland 21215-0036	i 2 should be filed won and Mental Hygier i e marked other traumatic event, In	To Be	Mitchell Murph	у				Ca	allie N	larsh	a11		
, Mai	ges 1 and 2 should t of Health and Men I if Itam 27 is marks or other traumatic		19a. Informant's Name/Relationship (Catherine Moye –	** *					Camp			Town, State, Zi	p Code) 748
more	Pages 1 nent of He ant: If Itan ury or oth		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dispo cemetery, crei rt Linc	matory`or ol	ther place		Date 3/31/20	007		ation - City or T	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	Mille					Fort Rd.,			Funeral d, MD 2	Home 20722
# #	Physician /Medical Examiner polysician up project proj	ai Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions from the cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	one cause on each line.	MER () equence of):							ige .	Approximate Interval Between Onset and Death
O. Box 68/	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	d. 23c. If yes, outcome of preging the pregnant at time of the pregnant at ti	tal death 3	∃Ectopic pre ∃Other (spe					2	3d. Date of deliv Month	ery Day Year
rds, F	quires that n signed b	Ď	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying ca	ause giver	n in Part I.					he cause of death?
ř	The ete hi page	Completed								24a. Was autop perfor	rmed?	24b. Were auto prior to co death? 1 \(\subseteq Yes	opsy findings available impletion of cause of
VITAI H	Physiclan: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Manadal			-		of Death Che	eck only o	ne)		
6	Phys this aldi	ပ	1 ☐ Yes 2 ☑ No 27. Manner of Death		ER/Outpatier			4 🔁 14012				□Other (Special	(y)
ב	ding l	ion	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	Bc. Injury : Work?	at ? es 2⊡No	- 1	Describe h	low injury	occurred	
DIVISION	I or Attendation of Director:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm, str lify)			65 2 140	28f. L	ocation (S City or Tow	Street and m, State)	Number or Run	al Route Number,
-	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the tuner	edicai C	29a. Certifier 1 Certifying Ph	ysician: To the best of my kr liner: On the basis of examin and manner stated.	nowledge, death lation and/or in	n occurred a vestigation,	at the time in my opi	e, date and nion, death	place, and d occurred at	lue to the o	cause(s) a	and manner as s place, and due t	stated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				License					signed (Month,	
1			> bhum	(())		-	D 5	1526	0		Marc	ch 28, 2	2007
P	(2)	1	30. Name and address of person who o										
	7		Bahram Tishdad, M	.D., 7420 Mar	lboro P	ike,	Fore	stvil	1e, MD	20	747		
- Ew	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Sign	Judy.								

			State of Maryland / De		Mental Hygiene	
			1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No.	2007 070
	Physicia		Ella June Cranford		Month Day March 28,	/ Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		County of Death
			9307 Adelphi Road	Adelphi		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthda</i> 577-30-1019 1. M 2 F 78 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
<u>Ja</u> v	Director	,	Usual Residence of Decedent		June 8, 19	28 Maryland
	yland Iow at		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	a-fsh	ctor	Maryland Prince George's A	delphi		1 □ Yes 2 No
	ith th	Director	10e. Street and Number	10f. Zip Code	10g. Citiz	zen of What Country?
	s 23a	sral	9307 Adelphi Road	20783		USA 14. Race - American Indian,
	ter de item	Funeral I	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ★ Married 1 □ Yes 2 ₺ No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	o Rican, etc.)	Black, White, etc.
22	urs af al", or Exam	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify.ite
ה ה	2 should be filed within 72 hours after death with the Maryland and Mertal Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wo . DO NOT use retired)	rking 16b. Kir	nd of Business/Industry
7	vithin ne. han " e Me	шb	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)		
V	filed v Hygie ther t		12 17. Father's Name (<i>First, Middle, Last</i>)	Office Manager 18. Mother's Nar	ne (First, Middle, Maiden	Plumbing Surname)
ō	ld be ental ked o ic eve	To Be	Oliver Norwood	Rosa	Davis	
	shou and M s mar umat	-		iling Address (Street and Number or Ri		r Town, State, Zip Code)
2	s 1 and 2 should be filed within 72 hours after death with the Marylar f Healith and Mental Hygiene. If Healith and Mental Hygiene. If Healith and Mental Hygiene. Other traumatic event, the Medical Examiner must be notified at			307 Adelphi Road,	* '	ryland 20783
ב כ	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat		cemetery, c	position (Name of rematory or other place)	Date 20c. Lo	ocation - City or Town, State
	t. Pa rtmen rtant: rjury		Cemetery Cemetery	ie Flesbycerian	2007 Nee	lsville, Maryland
Ö	permit Depar Impor any in		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Francis J. Collin		
Į,			23a. Part1. Enter the disease, or complications that caused the death. Do not one			er Spring, MD 20901 Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	G		Interval Between Onset and Death
f 3.3	/Medical		disease or condition resulting in death) a. Metastatic Col Due to (or as a consequence of):	on Cancer		2 Years
	Examiner		Sequentially list conditions. b.			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	execut and al-trar	xan	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
0/00,	cate be executed physician and the burial-transit	dical	L _d			
0	tificat ng phy as th	ledi				
X O	ith cer tendir ir use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death	B □Ectopic pregnancy	2	23d. Date of delivery Month Day Year
	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month Day real
	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
necorus,	uires I sign Ild be	d by			1 ☐ Yes 2	XNo 3 Probably 4 Unknown
5	sw rec	Completed			24a. Was an	24b. Were autopsy findings available
ב	The Is	omo			autopsy performed? 1□ Yes 2 % X No	prior to completion of cause of death? 1 □ Yes 2 □ No
ומ	iclan: The certificate ector, pag	Be C	25. Was case referred to medical examiner?		ath (Check only one)	
5	this al dir	ျှ	1 Yes 252No Hospital: 1 Inpatient 2 ER/Outpat		lome 5 🗷 Residence 6	
200	ding F	ion:	27. Manner of Death 182Natural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe how injury	ry occurred
2	Atten	fical	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm,		28f. Location (Street and	d Number or Rural Route Number,
Š	al or safter	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, State)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier (Check only (C			
	the H hin 24 the F the F	Medi	one) and manner stated. 29b. Signature and title of certifier	29c, License number		
ı	1.	=	230. Signature and title of Certifier	D22775		te signed (Month, Day, Year) rch 29, 2007
,	10		30, Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		
				Avenue, #1300, Be	ethesda, Mar	yland
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	hack 1		

			1 - For State of Ma	ryland / Depa	artment of I			iene	The state of the s	11873
	Dhusia		Decedent's Name (First, Middle, Last)				2. Date of Deat Month		Vaar	3. Time of Death
	Physic /Medi		Joseph John Dec	Kelm	ann		04	02	Ö7	1928 M
1	Examir	ner	4a. Facility Name (If not institution, give street and number) St. Mans Hospital		4b. City, Town, o	drun	MD	4c. Count	Ma	ns
	Funeral Director		5. Social Security Number 6. Sex 7. Age 15 M 2 F 7. Age Usual Residence of Decedent	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	35	9. Birthpla Count NEW	
	Maryland f show	tor	10a. State 10b. County MD ST MARY S	10c. City, Town or Lo			<u></u>		10	d. Inside City Limits
	r 28a	rect	10e. Street and Number	MECHANICS	10f. Zip Code		10	g. Citizen of	What Count	ry?
	h with	a D	37489 EAST LAKELAND DRIVE		20659)		U.	S. A.	
980	within 72 hours after death with the Maryland ene. than "nature!, or Iteme 23a or 28a-f show ha Modical Exeminer must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent 8 Armed Forces? 1 ☑ Yes 2 □ N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra	ce - America ck, White, e	tc.
21215-0036	vithin 72 ho ne. han "natur ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	DO NOT use retire	during most of work	ing	6b. Kind of B		•
	Hygier Hygier ther the		11 17. Father's Name (First, Middle, Last)	WOOD	WORKER	18. Mother's Name	/Eirst Middle A		ORKIN	G
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, Ins M	To Be	JOHN J. DECKELMANN			GERTRU	DE (UNAV	AILABL	E)	
_	1 and Health tem 27		19a. Informant's Name/Relationship (Type, Print) DEBBIE STONE / DAUGHTER 20a. Method of Disposition	37489 20b. Place of Dispo	E. LAKE	LAND DR	MECHANIC Date 2	-	MD	20659
Baltimore	Page ment ant: if		1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	MD VETERA	ANS CEMET	ERY 200	7 C	HELTEN	HAM, N	MARYLAND
Ba	permit. Departr imports any inju		23a. Part1. Enter the disease, or complications that caused	M00641 30)195 THRE	E NOTCH R	D. CHARL	OTTE H	ALL, N	.HME.,P.A.
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ver co	^	ig, such as cardiac (or respiratory arre	st,		Approximate Interval Between Onset and Death
68760,	ate be executed by this cien and the burial-transit	dicai Examiner	Sequentially list conditions, any, leading to immousts cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of): CHF consequence of): consequence of):	espin	- AA	rest		7	1 monty
P.O. Box 68	ne death certific tha ett-nding p hed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 22c. If yes, outcome of 1 □ Live birth 2c. 4 □ Pregnant at 9 □ Unknown 2c.	Fetal death 3	Ectopic pregnancy Other (specify)	,			ite of deliver	y Day Year
	quires that the signed by all be detacted		Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob			cause of death?
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/ita	ysicien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?			26. Place of Death	Check only one			
ion of \	ding Phys n. After this funeral di	ation: To	1 Yes 25 No Hospital: 1 Inpatier 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28b. Time of	28c. Injur Wor	4 Nursing Ho	me 5 Resider 28d. Describe hor			
Division	al or Attendest s after death bi Director: ad in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Numl State)	ber or Rural	Route Number,
	To the Hospital or Al within 24 hours after of To the Funerel Directompletely filled in by	edicai (29a. Certifier (Check only one) Certifying Physician: To the best of and manner states.	examination and/or in-	n occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and mite and place,	anner as sta and due to t	ted. the cause(s)
)	To the I within 2 To the I complet	Me	29b. Signature and title of certified		29c. Licens	e number 62213	29	d. Date signe	d (Month, D	ay, Year)
			30. Name and address of person who completed cause of de S . PATEL , M.D. LEONARTOWN		,			1		
2	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 2007 32. Registra	V. MARYLAN 's Signature	<u>v_40030</u>					

			State of Maryland / Department	artment of Health and N	Mental Hygie	
	7 6		Registrar 1. Decedent's Name (First, Middle, Last)	initiate of Death	2. Date of Death	3. Time of Death
ŗ.	Physicia	_	John R. Dorsey		March 3	0 2007 2:01 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			4616 East Leisure Court	Ellicott City		Howard
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F 7 Yrs.	if Under 1 Year if Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
b	Director		220 20 1123 80 80 Usual Residence of Decedent		Aug 30,	1926 Maryland
	/land		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Man a-f sh fied	ţ	MD Howard Ellicott	: City		1 □Yes 2 XNo
	th the or 28;	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	23a ust b		4616 East Leisure Court	21043		United States
	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 □ Never Married 22 Married 127 Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1944–46	1 ☐ Yes 2 ☑ No Specify:		Specify: White
Ş	2 hou atura cal E		15. Decedent's Education 16a, Dece	dent's Usual Occupation	16b	Kind of Business/industry
215	thin 7. e. an "n Medi	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	King	
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nd	be fill tal H doth even	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maio	,
$\frac{3}{2}$	2 should be filed and Mental Hygi is marked other aumatic event, t	욘	Thomas Anthony Dorsey		etta DeBau	
Maryland 21215-0036	りもいす			ng Address (Street and Number or Rur East Leisure Cour		
Ze,	es 1 a of He litem		20a. Method of Disposition 1 □ Burial 2 XI Cremation 3 □ Removal from State	osition (Name of matory or other place)	Date 20c	c. Location - City or Town, State
altimore,	permit. Pages Department of Important: If it any Injury or o		4 □ Donation 5 □ Other (Specify) Metro Cr		I .	tonsville, MD
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licensee M01044 41	^{2. Name and Address of Facility} Har L <u>12 Old Columbia</u> F	ry H. Wit	zke's Family FH Inc. ott City, MD 21043
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and in position of the Funeral Director, page 2 should be detached for use as the bunal-transit of in the funeral director, page 2 should be detached for use as the bunal-transit of in the funeral director, page 2 should be detached for use as the bunal-transit of in the funeral director, page 2 should be detached for use as the bunal-transit of in the funeral director, page 2 should be detached for use as the bunal-transit of in the funeral director.	ledical Certification: To Be Completed by Physician/Medical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Ectopic pregnancy Other (specify) Inderlying cause given in Part I. 26. Place of Deat At 3 DOA Other: Work? M 1 Yes 2 No reet, factory, office	23e. Did tobace 1 Yes 24a. Was an autopsy performed 1 Yes 2X th (Check only one) ome X Residence 28d. Describe how in the cause of the	23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 24No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 no 1 Yes 2 No
	To the within To the compile	Med	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
1	c. ,		30. Name and address of person who completed cause of death (Item 23a) (Type,	·		March 30, 2007
ت	1+1		E. Lee, 11065 Little Potul	rent Pkwy,	Colum	614, MD 21049
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 2 2007 32. Re (strar's Signature)	pent Pkwy,		
DH	MH 17 Rev 1/2	001				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician DAVIS Year Alton D. 16:06 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 (Months Days 8 Pear) 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 68 245-54-4299 NC Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits works i or 28a-f show notified at 1X Yes 2 □ No MD Howard Columbia Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or 3 5605 Mirrorlight Place 21045 Funeral death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bachelor-Cryptologist Government nd 2 should be filed value and Mental Hygie 27 is marked other ir traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be.
Department of Health and Mental H
Important if flem 27 is mer.
any injury or other Be Edward Davis Ruby Leonard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Davis - Wife 5605 Mirrorlight Pl. Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Clarksville, MD Columbia Mem. Pk. 4/2/07 4 □ Donation 5 □ Other (Specif 22. Name and Address of Facility Reese Professional F.S. 21. Signature of Funeral Service Lice 3605 14th St., NW Wash., DC 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Physician Intarction /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? furieral director, Be 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ▼ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) March 26, 2007

Registrar

State

#

DHMH 17 Rev 1/2001

5450 Knoll North DR. St 310 Columbia Md 21045

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

JACOB CHERIAN

31. Date filed (Month, Day

MAR 2 9 2007

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			Decedent's Name (First,	Middle I act)			Och inicate C	Death	2. Date of D	Reg. No.	-	3. Time of Death
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15-0	nature		15. Dec (Specify only i	edent's Educetion nighest grade comple	ted)	16e.	 Decedent's Usual Oc (Give kind of work do life. DO NOT use rel	cupation ne during most of w	rorking	16b. Kind of Bu	usiness/Ind	ustry
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Maryland 21215-0020	ould be filed Mental Hygi arked other atic event, I	Be	17. Father's Neme (First, Mi	roe . w-i		·		18. Mother's Na		a, Maiden Surnam	10)	
2	3392	ဥ	19a. Informant's Name/Rele			19b.	Mailing Address (Str			ber. City or Town.	State. Zip	Code)
Ž	A. (C) (R) (A)		JOYCE DAVIS				42 SUITLAN			ITLAND,		
re,	ges 1 and of Haali	Ì	20a. Method of Disposition			20b. Place of	Disposition (Name of		Date	20c. Location -		
E	Page nt: if ry or		MXBurial 2 ☐ Creme 4 ☐ Donation 5 ☐ Oth		rom State		DD CEMETER		3/29/07	GOLDS	BORO,	NC
Baltimore,	permit. Pages 1 and 2 Department of Haalth of Important: If item 27 is any Injury or other tre pnce.		21. Signature of Funeral Se	rvice Licensee	0							TYRE F.H.
	9.		23a. Part . Enter the disees	ea or complications to	at caused	the death. Do n	·	·			GOLD	SBORO, NC
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State Registrar DHMH 16 Rev 6/95 31. Date filed (Month, Day, Year) WAR 2 9 2007 32. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** Month William Dunn p^{M} March 27, 3:15 C. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12306 Dewey Road Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Under 14 Hrs. | Note of Birth (Month, Day, Under 15) | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 15 | Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 493-22-6128 1 M 2 □ F Months 82 Director Missouri Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitied at once. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12306 Dewey Road Funeral 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 1 XNever Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 Owner/Operator Interior Design & 18. Mother's Name (First, Middle, Maiden Surna Corating 17. Father's Name (First, Middle, Last) Be William Cecil Dunn မ Mary D. Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irma D. Robertson/ Sister 12306 Dewey Road, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory March 29 2007 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Şerviçe Licensee Francis Address Corrins Funeral Home Inc. 500 University Blvd, W, Silver Spring ,MD 20901 23a. Part1. Enter the disease, or complications that of sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Malignant Melanoma 13 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit that initiated even resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death Check onl one Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 **X X** o 2 ER/Outpatient 3 DOA 5□Residence 6□Other(Specificiter's P After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Residence Certification: To the Hospital or Attending 1 🖾 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 0101045261 March 28, 2007 Name and address of person who cougene I. Lambert, completed cause of death (Item 23a) (Type, Print) ., M.d. 1635 N. George Mason Drive, #430, Arlington, VA 30. Name and Eugene 31. Date filed (Month, Day, Year) State 2007 MAR 30 Registrar

			1 - For State Registrar	State of Maryla	nd / Depa	artment o		and Ment	•	211117	11878
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	Physici		D	aniel Ercolani					Onth	25 2005	NA O/
	/Medi Examir		4a. Facility Name (If not institution, given			4b. City, Tov	vn, or Location of			4c. County of Death	
46.4			14410 Brad Drive			R	ockvill	e		Montg	Omerv
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs	last birthday)	If Under 1 Y			ate of Birth fonth, Day, Ye	9. Birth	nplace (State or Foreign untry)
	Director		220-58-5196	1⊠M 2□F 56	Yrs.	Months	ays Hours		t.7,19		ington DC
	pu 🖈	1	Usual Residence of Decedent 10a. State 10b. County	100 C	ity, Town or Lo	anti		•			
	aryla shov	<u>_</u>	Toa. State	100.0	ity, TOWN OF LC	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	with th	Funeral Director	10e. Street and Number			10f. Zip Co	de		10g.	Citizen of What Co	intry?
	s 23s	ra	14410 Brad Drive	1.0 111-10-11-15	10 10		20853			ited Stat	
	er de Item	nue	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent If Yes, specify	of Hispanic Ori Cuban, Mexican	igin? (Specify Y n, Puerto Rican,	es or No- , etc.)	14. Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 21K1	No Specify:			Specify:	• • •
21215-0036	72 hours after death with the Maryland "neturel", or Items 23s or 28e-1 show digal Examinations! be intiffed at	ed	15. Decedent's E		16a, Dece	dent's Usual O	ccupation		16b	WΠ. Kind of Business/l	ite
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lan	ld be ental ked ic ev	To B	Fred Ercolani				Louis	se Lune	tta		
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Ž	and 2 ealth a n 27 ls		Gloria Crites/Sis	ter	4074	Sand T	ran Cour	rt. Mt.	Airv	Maryland	21771
re,	ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition	20b.	Place of Dispo	sition (Name o	of !	Date	-	Location - City or 1	
Baltimore,	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	Removal from State		Metho	dist Cer	/31/200	7	26	1 1
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			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			-,,		,		Interval Between Onset and Death
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		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):	711	12-4-16.11	On			WMINGE,
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,						
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89	tificate ig phys as the	edical		d							
XO	attending for use a	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancy					23d. Date of deliv	/en/
B	atter atter	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of		Ectopic pregn Other (specifi				Month	Day Year
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no	ding I h. After funer	tlon	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury		Injury at Work? 1 □ Yes 2 □ I		3301100 11011 111	ilary coodings	
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	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: / completely filled in by the fr		29a, Certifier 1X Certifying Pl	nysician: To the best of my kn	nwledge death	n occurred at th	ne time, date an	d place, and du	e to the cause	(s) and manner as	stated
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	To the within 2 To the complet	₩	29b. Signature and title of certifier		250	29c. Lic	cense number		29d. [Date signed (Month,	Day, Year)
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, s			30. Name and address of person who	completed cause of death (ltc.	m 23a) /Tunn					MARCH 2	
1	V		Nichala and address of person who	Completed cause of death (Itel	20	OH-F	DARNS	STOWN 0.	n cac	4. POTOMA	c 20878
	Sta	ite	31. Date filed (Month, Dath Reaf) 2	2007 32. Reservar's Sign	ature #	Arasta s	V. 11 4 6	1	١ الرواك	, (0,0,0,0)	
	Registr		Ut it of	LOUI LEGILLE	10	A STATE OF THE STA					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician March 25, 2007 Irene Ross Ferry 4:08 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 2**X** □ F Director 179-18-4813 84 June 15, 1922 Pennsylvania Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c City Town or Location r 28a-f show notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 3628 Old Washington Road 20602 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Home Owner permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Nem 27 is marked other any injury or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dominick Yacobucci Jeanette Valente 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick L. Ferry/Spouse 3628 Old Washington Road, Waldorf, Maryland, 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metropolitan Crematory 03/28/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign the of Funeral Service Licensee 22. Name and Address of Facility M00053 3035 Old Washington Road 18.1 Swhan Huntt Funeral Home Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PAJEC WADL disease or condition resulting in death) WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical as attending IF FEMALE nse 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Day 4☐Pregnant at time of death Year 5 Other (specify) P.0. the 9□Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, pe been sig 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has 24a. Was an page autopsy performe certificate 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 1 Minpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation Injury n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the P within 24 and manner stated 29b. Signature and title of certifier

State Registrar QU) LIN

E CENTER WALLONG Md. 2016

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year) MAR 3 0

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			1 - For State Registrar	State of M	larylan		artment rtificate			and M	-	giene Reg. No.	00	The state of the s	1880
74 E (3)	ِ Physicia	an	Decedent's Name (First, Middle, Anna	•	C.						2. Date of De Month		oth Ye	ear 3	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,	Elizabeth		unnin		Town or	Location o	of Death	March	- 1	2 County of I	COT	9.30pm
	Examin	er	Chapel Hill						allst				,	.more	2
F	uneral					last birthday)	If Under Months	1 Year	If Under						e (State or Foreign
Č D	irector		212-12-1663	1□ M 21XF	85	Yrs.	MOHUTS	Days	110013	IVIIII.	8. Date of Bir (Month, Da 3 / 28 /	1921		Mary	
and	W.		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d.	Inside City Limits
Mary	in the first	to	MD Car	roll	S	ykesv	ille								1 ☐ Yes 2 ∰ No
the	or 286	irec	10e. Street and Number				10f. Zip					10g. Citiz	en of Wha	at Country	?
ath wi	23a unit b	raiD	7426 Villag	e Rd. Ap	ot. 3	16	2	178	4			Un	ited	d Sta	ates
5-0036 72 hours after death with the Maryland	mportent: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Madical Examinar must be rutified at phos.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? tNo		Was Deced f Yes, spec 1 ☐ Yes 2			gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	1	Black, \	American White, etc. White	
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within ene.	Mas	Completed	Elementary/Secondary (0-12)	College (1-4o	5+)		kind of wor DO NOT us Mema)	O HOINI	<i>'</i> 9	05.77	n Ho		
a filed w	nt.		12 17. Father's Name (First, Middle, La	ist)		110	шеша	ver	19 Mothe	r's Name	(First, Middle,			me	
Maryland 21215-0036 nd 2 should be filed within 72 hours aff	is marked or sumatic eve	To Be	Russell	Charles	Bake				E.	liza	beth	Mari	е Ве		
Mar d 2 st th and	7 is n traun		19a. Informant's Name/Relationship Christopher S	tephen Gu	nnin	19b. Mailin	ng Address 6 Wi:	^{(Street} a nd I	nd Numbe Ridae	erorRuma. ∋Rd	Route Numbe	er, City or unt	Town, Sta Airv	ate, Zip Co 7 - MI	^{de)} 21771
	Itam 2 other		20a. Method of Disposition		20b. P	lace of Dispo emetery, cren	sition (Nam	10 01	al I	D	ate	20c. Loc	ation - Cit	y or Town,	State
Page Page	ant: H		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		D	ulane Memo	y Va	lley	Ϋ́ M̄́́	ar. 2007		Тi	moni	Lum,	MD
Baltimore, Sermit. Pages 1 at Department of Hea	mport any inj page.		21. Signature of Funeral Service Lie	censee		22	. Name and	d Address	s of Facility	V					
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/M Exa	sician edical miner	ner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Adult Due to (or a	Fail s a conseque	uence of):	to The	1211	VO					Int	erval Between iset and Death
. Box 68760, death certificate be executed	ng physicien and as the burial-translt	ledical Examiner	trial initiated events resulting in death) Last	c. Due to (or a	s a consequ		Sto	20	1						
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	De g	þ	Part II. Other significant condition	s contributing to death	but not resu	ulting in the ur	nderlying ca	luse give	n in Part I.		23e. Did t		/		ause of death? 4 □Unknown
a §	is certificate has be director, page 2 sh	Completed									24a. Was autor perfo 1 🗆 Yes	osy rmed?	prior deat	r to comple th?	findings available etion of cause of No
Vit.	certif) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		FB/0		Dthe			(Check only o				
Vision of Vita Attending Physician: or death.	After this unerel di	on: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In		ER/Outpation 28b. Time of Injury	28	Bc. Injury Work	at ?	2	ne 5 Resident			(Specify)	
Division or Attendate death	To the Funeral Director: After the completely filled in by the funeral	Certification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determine	be 28e. Place of Ir	njury - At ho tc. (Specify	me, farm, stre	M eet, factory,		′es 2 □ l		Bf. Location (S City or Tox		Number o	or Rural Ro	oute Number,
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o the	o the	Med	29b. Signature and title of certifier	and manner s	tated.			License						Month, Day	
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WJ 5			30. Name and address of person when the second seco	completed cause of	death (Item						role, r				
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		For		-	epartment o		d Mental Hy	/giene		
		- State Registrar Amend Line	31 per Health	n Dept. KG (Certificate o	of Death		Reg. No.	200	7 1188
nysicia	an	Decedent's Name (First, Middle,	Last)				Date of D Month	eath Day	Year	3. Time of Death
Medic		MARIE THERESA GA					MARCH	13,	-	
xamin	er	4a. Facility Name (If not institution,			4b. City, Tow	n, or Location of De	eath		County of Dea	
		5. Social Security Number 6		R ge (In yrs. last birth	ANNAPO If Under 1 Yo		Hrs. 8. Date of B		NE ARU	INDEL_ rthplace (State or Foreig
neral ector		215-09-8273	1 M 2 M F	0.0			lin. (Month, D	lay, Year)	C	ountry)
J. (U)		Usual Residence of Decedent					MARCH 2	13 و 23	7ZU FIAR	CILAND
at	. [10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limit
event, the Medical Examiner must be notified at	cto	MARYLAND QUEEN	ANNE'S	STEVENS	VILLE					1 ☐ Yes 2 X No
9	Directo	10e. Street and Number			10f. Zip Cod	de		10g. Citiz	en of What C	country?
i Par		120 NICHOLS MANO			21666			US		
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	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 😿 If Yes, Give Year or Dates:		1 ☐ Yes 2 📆	No Specify:			Specify: W	HITE
	Pa	15. Decedent's			Decedent's Usual Oc	ccupation		16b. Kir	nd of Business	s/Industry
	plet	(Specify only highest	grade completed)	(Give kind of work do life. DO NOT use re	one during most of	working		,	
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	Be C	17. Father's Name (First, Middle, La	ast)			18. Mother's I	Name (First, Middl	e, Maiden	Surname)	
	To B	FREDERICK RATAJO	ZAK			BERTH	ARCZYSZ	EWSKI		
	Γį	19a. Informant's Name/Relationship	p (Type. Print)	19b. l	Mailing Address (Str					Zip Code)
		ROBERT GALLAGHER	JR./SON	32	O CENTREV	TLLE ROAI	O, QUEENS	TOWN.	MARYL	AND 21658
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once.		21. Signature of Funeral Service Li)	22. Name and Ad	ddress of Facility				
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10		Immediate Cause (Final	T'D ATTM		or enter the mode of	dying, such as car	diac or respiratory		MU	Interval Between Onset and Death
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ıl		disease or condition resulting in death)	Due to (or as	A	f):			1.5	Dr. LI	Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene []

Amend Item 20b per In, 8866 194 1.18 / 0 / dhb

Certificate of Death

Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 7:45P M Greenfield Francis March 28,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 44 Brookside Place Waldorf Charles If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1⊠M 2□F 219-46-9665 59 Yrs. 10-16-1947 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itama 23e or 28e-f show any Injury or other traumatic event, the Medical Exeminary. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Maryland Charles Waldorf 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 44 Brookside Place 20601 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🔀 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Holly Station Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ignatius Greenfield Elsie Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Agnes Greenfield-IN-Law 44 Brookside Place Waldorf Md 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 04/03/2007 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, MD St.Peters Cem 21. Signature of Authoral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA, Aquasco MD20608 191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) carcinoma throat **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner attending physicien end for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan hes autopsy performed 1 Yes

The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. Hospitel or Attending Physician: Be 2 this After Certification: death.

Diractor

within 24 hours a To the Funeral (

Medical

25. Was case referred to medical examiner? 26. Place of Death (Check only one, 2 ER/Outpatient 3 DOA

2 No

Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☑ No 27. Manney of Death 28a. Date of Injury (Month, Day Year) 1 Matural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3328 dd WASHINGTON Rd

NORF,

1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

4 Homicide

29a. Certifier

29c. License number D45737 29d. Date signed (Month, Day, Year) 3/29/07

20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRMALADEVI

Jayanthan ,m,d

State Registrar

31. Date filed (Month, Day, Year) APR 0 2 2007

			1 - For State Registrar	State of Mar			irtment of H		Mental Hy	giene Reg. No.		11085
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of De		Year	3. Time of Death
	/Medic Examin	cal	4a. Facility Name (If not institution, give	a OVV e street and number)			4b. Cily, Town, og	Location of Death	March	2/1 4c.	2007 County of Death	2:40 PM
	EXAMILI	ier	Merry Medic	al Ceu	ter		Bal	finen			non	
	Funeral Director		5. Social Security Jumber 6. S 204–12–3059	7. Age (In yrs. last biri 7	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da 9/27/	th ay, Year) 1919	9. Birth Cou Pen	place (State or Foreign ntry) nsylvania
	land Dw		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	n or Lo	cation					10d. Inside City Limits
	a-f eh	ctor	Md. Howard	E	Ellic	cott	City					1 ☐ Yes 2 🕍 No
	with the	Dire	10e. Street and Number 4126 Dee Jay Di	ciszo			10f. Zip Code 210	40		10g. Citi	zen of What Cou	ntry?
	me 23	Funeral Director	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of Hi	spanic Origin? (S	pecify Yes or N	o-	USA 14. Race - Ameri	
220	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if item 27 is marked other than "netural; or items 23s or 28s-f show says injury or other traumatic event, the Madical Examinational to Examinational and once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1	Yes, specify Cuba ☐ Yes 2 No	Specify:	o Hican, etc.)		Black, White, Specify: Wh:	ite
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7	be filed ita! Hyg ed other event,	Be	17. Father's Name (First, Middle, Last,)	<u> </u>			18. Mother's Nan				
Z	should ind Meni	은	Owen Morgan 19a. Informant's Name/Relationship (Type Print)	196	Mailin	g Address (Street a		a Pickei		r Town State Zi	n Code)
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2	Pages 1 and of He not of He not: if item		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐		20b. Place of cemeter	Dispo ry, cren	sition (Name of natory or other place	e)	Date	20c. Lo	cation - City or T	own, State
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2	ath cert	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death		Ectopic pregnancy			2	23d. Date of deliv	rery Day Year
	the deay the eached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at tir 9 Unknown	ne of death	5 🗆	Other (specify)					
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5	ng Phy Iter this neral d	on; To	27. Manner of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day)	28b. 1	Time of njury	t 3 DOA	4 🗆 Nursing n	28d. Describe		y occurred	TY)
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	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificete hes been signed by the eltending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of experience: On the basis of example and manner state	kamination an	d/or inv	occurred at the time vestigation, in my op	ne, date and place pinion, death occu	, and due to the irred at the time	cause(s) date and	and manner as: place, and due	stated. to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifier	110 4-	C		29c. License	number		29d. Dat	te signed (Month	Dey, Year)
5	-		30. Name and address of person who	completed cause of dea	th (Item 23a)		1	0577		WC	wal.	51,0001
_			J.NAZACIAN	MD 3	DI 8T	PC		Baltin	love, N	10	21201	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 2	2007 32. Registrar's			best !		,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Cecil Herbert Grimmett, Jr. 200 Murch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 91110 Bultimore Washington medical conter 8. Date of Birth (Month, Day, Year) Jan. 24, 1943 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** West Virginia 1 XM 2 □ F 64 Jan. Director 232–66–3612 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1X Yes 2 No Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified. Director MD Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21144 7959 Telegraph Rd. Apt. #138 Funeral 12. Was Decedent Ever in U.S. Argued Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1960–64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Prince George's Co. Police Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Bailes Cecil H. Grimmett, Sr. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2240 Legion Dr. #215 Signal Hill, CA 90755 Frances M. Grimmett / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. Veterans Cemetery 04/02/2007 Cheltenham, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Beall Funeral Home Bowie, MD. 6512 NW Crain Hwy. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pulmonari Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine for use as the burial-transi and Due to (or as a consequence of): Box 68760. attending physician death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) i signed by the aid Id be detached fo P.0. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 9 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Division Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

MAR 2 9 2007



of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007

		•	For State Registrar		State of Ma	путапо			te of E		na ivie		glerie Reg. No.	KUU/	11660
			1. Decedent's Name (First, Mic	idle, Last,)						2	Date of Dea	ith Day	/ Year	3. Time of Death
	Physicia /Medic		Perla	Y	amileth	U:	rias		Gard			larch	27.	2007	11:00a ^M
j.	Examin		4a. Facility Name (If not institut	_						Location of	Death		4c.	County of Dea	
			Holy Cross					i .		Spr If Under 2		D 11 1/ D'11		lontgo	
I	Funeral Director		5. Social Security Number none	6. Se:	7. Age	(In yrs. las	Yrs.	Months		Hours	Min.	. Date of Birti (Month, Day 3 / 27 /	Year) 200	7 Ma	thplace (State or Foreign ountry) ryland
	and	1	Usual Residence of Decedent 10a. State 10b. Cour	nty		10c. City, 7	Town or Lo	cation							10d. Inside City Limits
	Manyi f eho	ŏ	MD Mon	tgom	ery	Sil	ver	Spri	ing						1 ☐ Yes 2 🖾 No
	the 128e-	Director	10e. Street and Number					10f. Z	p Code				10g. Citi	izen of What Co	ountry?
	h with	<u>=</u>	648 Northan	npto	n Drive	Apt.	A	2	20903	3				USA	
	deat	Funeral	11, Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Deci	edent of His	spanic Origi	n? (Speci	fy Yes or No- can, etc.)		14. Race - Ame Black, Whit	
Maryland 21215-0036	s 1 and 2 should be tiled within 72 hours after death with the Maryland if Heelih and Mental Hygiene. Item 27 is marked other than "naturel; or iteme 23e or 28e-f ehow other traumatic event, its Medical Examinal mast be notified at	Ď	1 Never Married 2 N 3 Widowed 4 Divorce		1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo			2□ No E	Specify:		oren			hite
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<u>~</u>	2 should and Men is marke aumatic	2	19a. Informant's Name/Relation				10h Mailir	a Addres	s /Street a					r Town, State,	Zio Code)
<u>8</u>	d 2 si th an t7 is r		Nelson I.G					•	,						
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ē	ages ant of it: it ii		1 ☑ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		Removal from State	1	e of				/02/	/2007	Sil	lver S	pring,Md
Baltimore,	permit. Pages 1 and 2 Department of Heelth a Important: If Item 27 is eny injury or other tra		21. Signature of Fyneral Servi		A. 1	Juc						-			CE,P.A.
m	Ded P a		> XILele	DR	undos		9	241	Coli	mbia	Bli	d.Si	lvei	Spri	ng,Md20910
			23a. Part 1. Enter the disease shock, or heart failure. I	or comp	lications that caused ne cause on each lin	the death.									Approximate Interval Between
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H	/Medical Examiner		resulting in death)		Due to (or as										
	Examine	_	Sequentially list conditions,		b										
	ed sit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to (or as a	a consequer	NOU LOTS!								
	and al-trar	Examiner	that initiated events resulting in death) Last		c Due to (or as a	a consequer	nce of):	_							
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.89	ifficat g phy as the	ledicai											-		
	endin use	7	IF FEMALE: 23b. Was decedent pregnant	1	23c. If yes, outcome			Tectonic	oregnancy					23d. Date of de	
B	thet the death cer ed by the attendin deteched for use	by Physician/M	in the past 12 months? 1 □ Yes 2 □ No		4☐Pregnant at			Other (Month	Day Year
<u>Ч</u>	d by the	Phy	9 ☐ Unknown** Part II. Other significant cond	litiana aa		at mot constitu	an in the			n in Dani I		220 Did to	hacco i	.co.contributo t	o the cause of death?
Division of Vital Records, P.O. Box	Attending Physician: The law requires thet the death cer rideath. sctor: After this certiticate has been signed by the attendin by the funeral director, page 2 should be deteched for use		Part II. Other significant conc	introns co	ninbuting to death bu	It not resulti	ng in the u	nderlying	Cause give	m m rait i.	_		es 2		robably 4 Unknown
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æ	The I	E										perfo	rmed? 202 No	death?	s 2 No
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Ĕ	Ing P		27. Manner of Death 1 Natural 5 ☐ Per		28a. Date of Injur (Month, Da)	Year) 2	8b. Time o Injury		28c. Injury Work			id. Describe i	now injur	ry occurred	
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$\overline{\underline{Z}}$	i	Certification:		ermined	28e. Place of Inju- building, etc	S. (Specify)	e, iarm, sti	reet, racio	гу, опісе		20	City or Tov			lural Route Number,
	To the Hospital or Attending Physician: The law within 24 horus after death. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2	Medical C			rsician: To the best of iner: On the basis of and manner sta	examination									
	omple	Me	29b. Signature and Mile of gen	ifier	A.			2	9c. License	number			29d. Da	te signed (Mon	th, Dey, Year)
	r>=0		> LLA	fel	hers mo			i	745	369	7		03	127/20	007
			30. Name and address of pers	on who c	ompleted cause of de	eath (Item 2	3a) (Type,	Print)							
			Alan Goldb					Gler	1 Ro	ad	511	ver Sf	rin	g, MD	20910
1	Sta Registr		31. Date filed (Month, Day, Ye MAR 3		32. Jegistra	ars Signatur	de de	sele	,						

			• •		. Ensure All Copies Health and Mental Hy	
		1 - For State Registrar	State of Maryland	Certificate of		Reg. No. 0 0 7 1 886
Physic /Medi		1. Decedent's Name (First, Middle, Last) Tames AvH	nur Griff		2. Date of D Month	Peath 3. Time of Death
Exami		4a. Facility Name (If not institution, give: Raltinove Rehabili	street and number) tation Extended	Care 4b. City, Town, o	or Location of Death	4c. County of Death
Funeral Director		427 32 1103	7. Age (In yrs. las	st birthday) If Under 1 Year Months Days	Hours Min. (Month, D	Jay, Year) 9,1922 9,1932 9,1932 9,1932 9,1932 9,1932
Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince		Town or Location Laurel		10d. Inside City Limits 1
h with the 3s or 28s	Funeral Director	10e. Street and Number 8905 Merrill	Lane, #102	10f. Zip Code	0708	10g. Citizen of What Country? U.S.A.
72 hours after death with the Maryland 72 hours after death with the Maryland natural; or items 23a or 28a-f show after Experiment must be notified at	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Marned 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 43-63	1 Ves 2 No	Hispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
d within 72 hours af giene. er then "natural", or the Mudical Exert	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b. Kind of Business/Industry
VILL Y IGNICA & LEAR 12 should be filed within 1 h and Mental Hygiene. 7 is marked other than " traumatic event, the Mark	Ве Сош	12th 17. Father's Name (First, Middle, Last)	condge (1 vo. ov)	Securi	18. Mother's Name (First, Middle	Dept. Of Agricul
Menta Menta Menta mrked	To E	James Grif	fin		Viola Mat	this
and 2 should be file asith and Mental Hy n 27 is marked oth ar traumatic event		19a. Informant's Name/Relationship (Ty Donald Mosley	(Nephew)	8119 Hicks	Road, #B, Jes	ber, City or Town, State, Zip Code) Ssup, MD 20794
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Expuring must be notified at ance.		20a. Method of Disposition 12 Burial 2 Cremation 3 F 4 Departion 5 Other (Specify) 21 Signature Funeral Service Libers	Arli		Cem 4/12/07 Poss of Facility SNOWDEN	7 Ft. Myer, VA FUNERAL HOME, P.A. Rockville, MD 20850
Priysician /Medical Examiner	Ilcal Examiner	23a. Part. Enter the disease, or common shock, or hear failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent of the total) Due to (or as a consequent of the total) Due to (or as a consequent of the total)	e Dement not enter the mode of dyn e Dement not enter the mode of dyn Avtevy D not enter the mode of dyn not enter the mode of dyn e Dement not enter the mode of dyn e Dement not enter the mode of dyn e Dement not enter the mode of dyn e Dement not enter the mode of dyn e Dement not enter the mode of dyn e Dement not enter the mode of dyn e Dement not enter the mode of dyn e Dement not enter the mode of dyn not enter the mode	ng, such as cardiac or respiratory	
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To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		8b. Time of lnjury 28c. Injury Wo	y at ck? Yes 2 □ No 28d. Describe	(Street and Number or Rural Route Number, own, State)
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To the within To the comple	Me	29b. Signature and title of certifier		1,D, 29c. Licens	se number 1365	29d. Date signed (Month, Day, Year) March 10, 2007 Battimore, MD, 21219
		30 Name and address of person who co George E. Will	mpleted cause of death (Item 2	3a) (Type, Print) Och Raven	Boulevard 1	3 attimore, MD. 21219
Sta Regist		31. Date filed (Month, Day, Year) MAR 3 0 200	32 legistrar's Signatur	Società D		

			State of Maryland				and Me	ntal Hy	giene	200	17		ΩΩ
			1 - State Registrar	Certiti	cate of	Death		. Date of De	Reg. No.	401	J 1	3. Time of	Dooth :
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	/Medic		Chester Murray Gordon 4a. Facility Name (If not institution, give street and number)	4b.	City, Town, o	r Location o		arch		200 County of		12:5	/ A
لع	Examin	er	3330 N. Leisure World Blvd., # 6		ilver					lontgo		V	
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If I	Jnder 1 Year			. Date of Bir (Month, Da	th			ace (State o	or Foreign
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	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Locatio	n						10	d. Inside C	ity Limits
	faryla shoved	ō		Lver Spi									2 No
	the N	Director	Maryland Montgomery Sil		of. Zip Code				10g. Citi	zen of Wha	at Count	ry?	
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Ö	be filed within 72 hours after death with the Marylar tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)					First, Middle,		Surname)			
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Maryland 21215-0036	es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. f item 27 is marked other than "natural", or items 23a or 28a-f show r other traumatic event, the Medical Examiner must be notified at			19b. Mailing Ad								,	
	and tealth m 27 her tr		Shelley B. Gordon - Daughter	8200 C:		ine, B	3ethes Dai			and Zincation - Cit			
Baltimore,	Pages 1 nent of 1- int: If ite		1 X Burial 2 □ Cremation 3 A Removal from State	netery, cremator Bavid	rv or other plac	dns	3/27/				•	wn, State 1, Vir	ginia
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VIS	or Attendafter death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At hom building, etc. (Specify)	ne, farm, street,	factory, office		28	f. Location (Street ar	d Number	or Rura	Route Nun	nber,
	talor rs afte al Dir	Cert	Salaring, etc. (openity)					0.0, 0. , 0.	,	,			
	Hospi 14 hour Funer tely fill		29a. Certifier (Check only (C	ledge, death <i>oc</i> o on and/or investi	curred at the ti gation, in my	ime, date an opinion, dea	nd place, ar ath <i>o</i> ccurred	nd due to the d at the time,	cause(s date an) and manr d place, an	ner as st d due to	ated. the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, I	Medical	one) and manner stated. 29b. Signature and title o certifier		29c. Licens	se number			29d. Da	te signed (Month I	Dav. Yearl	
	T. N S					29675				ch 26			
	15		30. Name and address of person who completed cause of death (Item 2	23a) (Type Print		27017			ııaı	C11 Z(, 2		
				ckledge		, Sui	te 41	00, Be	thes	da, M	id.	20817	
N.	Sta	te	31. Date filed (Month, Day, Year) 32. Segistrar's Signatu		-								
	Registi	ar	MAR 3 0 2007	Cose									

Physici		Decedent's Name (First, Middle, Last) Zelie	Leucy	Houpt			2. Date Mon	of Death_ th [Day Ye	3. Time	of Deat
/Medic	_	Zelie	Lucy		Hot			Apr	11 4	, 200	7 2020	
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		17317 Diane Drive 5. Social Security Number 6. Se	7 Ac	ge (In yrs. las		gersto	WN If Under 24	Hrs. 8. Date	of Birth	. 9	ington Birthplace (State	or For
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nark mark matic	ဥ	Jean Cheviel Cha			19b. Mailing Addre	ess (Street and		ine Bo		v or Town. Sta	ate. Zin Code)	
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State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** 28, Roger Norman Hooker March 2007 07:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Hospital of Cecil County Cecil. Elkton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs. 226-58-4065 63 Nov. 9, 1943 Director Washington, D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location r than "natural", or iteme 23s or 28s-f show the Modical Examiner must be notified at 1 X Yes 2 □ No Be Completed by Funeral Director Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21901 59 Sycamore Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: Air Force 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Software Salesman Computer les 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie if itsm 27 is marked other in other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert E. Lee Hooker Ida Elizabeth Swaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 59 Sycamore Drive, North East, Maryland 2190 ce of Disposition (Name of Date 20c. Location - City or Town, State Anne Murphy / Wife 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March Pages 1 nent of P 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department of Important: If any njury or once. ō 4 Donation 5 Other (Specify)
21. Signature Funda Servic License Mayerdale Crematory 29, 2007 Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypoxic Z drys tailure resportery /Medical Que to (or as a consequence of): Examiner 7 des Due o (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical JE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 🗆 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Alcoholic Carryosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Kecurreyt ascifes 24a. Was an page 2 autopsy performed Protecy N No certificate CFlorie malgowiti Strine 1 Yes 2 No 1 Tes or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death | Check only one 1 Yes 2 No Hospital: 1 ☐ Phopatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pendina death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Murch 28 2007 00055190 aske afterney 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L+ IVA Bow Street Elktuy MAD Itospetal 106 MB Varion 3 0 2007 32. Registrar's Signatur State Registrar

			For State Registrar	State of Ma	aryland / I	•	tment of			ntal Hy	giene Reg. No.	007	Part of the second	890
			Decedent's Name (First, Middle, L.)	.ast)					2	. Date of De	eath		3. Time o	of Death
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	/Medio		4a. Facility Name (If not institution, g	ive street and number)		4	b. City, Towr	, or Location	n of Death		4c. C	ounty of Death		
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21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of	Education	16a	. Deceder	nt's Usual Oc	cupation	act of working		16b. Kind	of Business/II	ndustry	
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<u>Xa</u>	Meni Meni arke	ဥ	Benjamin H. Higo						a G. R					
Mar	2 short and is m		19a. Informant's Name/Relationship									Town, State, Zi		-
	and lealth m 27		Mildred Gayle Hig	ggs - Wile					ROad		• 1000	aryland)
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State	cemete	ery, crema	ion (Name of tory or other) Ceme	place)	4/2/20			ation - City or T Vindsor		Fore Iv
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e n	permit. Pages Department of I Important: If its any Injury or o		21. Signature of Eureral Service Lice		M001490		Name and Ad in Stre		EIII			Home, 9		ıth
	- 8		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do	not enter	the mode of	dying, such	as cardiac or r	espiratory a	arrest,		Approxima Interval Be	etween
7	Physician		Immediate Cause (Final disease or condition	We	TATA	TIC	6	0	CAN	10			Snset and	Death
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VITal	ifficat		25. Was case referred to medical					26 Pla	ice of Death (6	1□ Yes	2 No	1 ☐ Yes	2□ No	
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UNISION	I or Attendi after death. Director: A I in by the fu	iffic	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	Zoe. Place of III	ury - At home, fa c. (Specify)	arm, stree	t, factory, offi	ce	28	Location ((Street and i	Number or Ru	al Route Nu	mber,
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withi To t WJL

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAR 3 0 2007

32. Registrar's Signature

ORIGINAL

		For State	State o	f Mary	/land /		artment of H			lental Hy	/gien	e	07	11001	
		Registrar 1. Decedent's Name (First, Middle	(ost)			Cer	tificate of	Deati	n ———	2. Date of De	Reg. N	loc U	UI	3. Time of Death	
Physicia		Sandra Huffman	, Lasi)							Month March	D	ay 200	Year	M	
/Medic Examin		4a. Facility Name (If not institution	, give street and nu	mber)			4b. City, Town, o	r Location	n of Death	nar en			y of Death	7:45 PM	
		Crofton Convale	escent Cer	nter			Crofton				A	nne	Arun	de1	
Funeral Director		5. Social Security Number 233-58-3363	6. Sex 1 ☐ M 2 ☐ XF		n yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bi (Month, D. 12/16/	ay, Yea	7	9. Birth Cou Mary	place (State or Foreign Intry) 1 and	
70		Usual Residence of Decedent													
arylan show d at	_	10a. State 10b. County			c. City, Tov		cation							10d. Inside City Limits 1 X Yes 2 □ No	
he Ma 28a-f	Director	Maryland Anne	Arunde1	C	rofto	n	10f. Zip Code				10g. Citizen of What Country?				
3a or	io I	1908 Pawlet Dri	ve				21114				USA		What oou	muy:	
death	Funeral	11. Marital Status	12. Was Dece		r in U.S.	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								ican Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced		2 X No ve			Tes, specify Cubi	Specii		riidan, etc.)		Specif	ick, White	ite	
2 hour	ted t	15. Decedent	's Education	atos.	168	16a. Decedent's Usual Occupation (Give kind of work done during most of working						Kind of B	WII Business/Ir		
thin 7: e. an "n Medi	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)		(Give kind of work done during most of working life. DO NOT use retired)						ernm		_	
led wi lygien her th nt, the		12. Father's Name (First, Middle,	1 4)		Ad	mini							Hil	1	
d be fi	Be	Tony Frank Scr	ŕ				18. Mother's Name (First, Middle, Maiden Surna Mary Yvonne Kuhn								
should nd Me mark	ရ	19a. Informant's Name/Relations			19	b. Mailin	ig Address (Street					or Town	, State, Zi	ip Code)	
and 2 ralth a 27 is		James A. Bennett/ Husband 1908 Pawlet Drive Crofton, MD 2111													
of He of He if item or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from	State	20b. Place of cemeto	of Dispo: ery, cren	sition (Name of natory or other place	ce)	I	Date	20c.	Location	- City or T	own, State	
t. Pag tment tant: njury o		4 ☐ Donation 5 ☐ Other (S	pecify)		Memoi	rial	isposition (Name of crematory or other place) kemont all Gardens 03/30/2007 Davidsonville, MD								
permil Depar Impor any In once,		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans F 16000 Annapolis Road Bowie, MD 20												al Home	
Lake K		23a. Part1. Enter the diseas or shock, or heart failure. List	complications that conly one cause on e	caused the	death. Do	not ente	er the mode of dyir	ng, such a	as cardiac	or respiratory	arrest,			Approximate Interval Between	
Physician	8 0	Immediate Cause (Final disease or condition	_a. P		mo		4						1	Onset and Death	
/Medical Examiner		resulting in death) Due to (or as a consequence of):												2 2 7 6 8	
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Due to (or as a consequence of):											-	months	
cate be executed ohysician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as Consequence of): Al 2 humble Disease Consequence of):											Hous		
oe exe cian al													9		
physics the t	dical		d												
leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou				Te					23d. Da	ate of deliv	very	
e death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at tim	☐ Fetal deat ne of death		Ectopic pregnancy Other (specify)	У				M	onth	Day Year	
at the ded by the setached	Phy	9 ☐ Unknown Part II. Other significant condition			ot rossiting	in the ur	adartying cause aiv	on in Par		23a Did	tobacco	O LISO COR	stributo to	the cause of death?	
w requires that been signed to should be deta	Completed by	Chronic of		マレー	- Vu	0 -	onany	· 1-	Sea			2 N o	3 ☐ Pro		
aw req	olete)			24a. Was		24b.	Were aut	opsy findings available	
Physician: The larthis certificate has all director, page 2	mo					-				auto perf 1⊟ Yes	ormed? 2 ⊋ 1		prior to co death? 1 ☐ Yes	ompletion of cause of 2 ☐ No	
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					044			h (Check only					
Physi this c	٦	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 28a. Date	Inpatient of Injury	2 ER/O	outpatien Time of		46		me 5 Res				ify)	
ding th. After funer	tion	1 Natural 5 Pendin 2 Accident investig	g (Mon	th, Day Ye		Injury	Wor	k? Yes 2		Zou. Describe	TIOW III	july occu	neu		
Atter er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		farm, stre	eet, factory, office			28f. Location	(Street	and Num	ber or Rui	ral Route Number,			
ital or irs afte ral Di															
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)										stated. to the cause(s)				
To the To the COM	Ň	29b. Signature and title of certifier	ah a	10	201	MI)	29c. Licens		108	2	29d. E	Date signe	ed (Month	, Day, Year)	
		30. Name and address of person	•						00 =			71.5	<u> </u>		
	•	Rakesh Arora, M. 31. Date filed (Month, Day, Year)	1.D. 14300	Ga1	Lant Signature	Fox	Lane Sui	te 2	22 Bo	wie, MI) 20	/15			
Sta Registr		MAR 2 9	2007	Core	Signature	A									

1	
	Physician
	/Medical
	Examiner
100	
	Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

Division or Vital Records, P.O. Box 68760,

	State Registrar					Cer	tificate of	Death	1		Reg. No	200)7		892
	1. Decedent's Name	e (First, Middle	e, Last)							2. Date of De			V	3. Time	of Death
2	Wi11	iam	L. Her	ron						Month March	28		Year 007	3:	57 A ^M
	4a. Facility Name (I						4b. City, Town, o	or Location	of Death			c. County of			3, 11
ı				ŕ								E	1	-1-	
	5. Social Security N		n Manor 6. Sex	7. Age ('In yrs. last bii	rthdav)	If Under 1 Year	erick If Unde	r 24 Hrs.	8. Date of Birt	th		deric 9. Birtho		e or Foreian
	405-20-		1 XM 2□ F			Yrs.	Months Days	Hours	Min.	(Month, Da		·			e or Foreign
ŀ	Usual Residence of			85						Feb. 8,		22 11	Massa	achus	etts
ŀ	10a. State	10b. County		1	0c. City, Tow	n or Loc	ation						1	10d. Inside	City Limits
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	Maryland		derick		Free	deri	T				10 0				
	10e. Street and Nur	mber					10f. Zip Code					itizen of W			
	841 Dunb	rooke	Court				1	21701				ted S			
	11. Marital Status			ecedent Ev Forces?	er in U.S.	13. W	as Decedent of I Yes, specify Cub	Hispanic Or san, Mexica	rigin? (Span, Puerto	pecify Yes or No Rican, etc.)	-		e - Americ k. White,	can Indian, etc.	
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	3 Widowed	4 Divorced	Year or	Dates:	1946			Opecny	•			эреспу.	WIII	LE	
	/Snoo	15. Deceden	t's Education	al)	16a	. Decede	ent's Usual Occu	pation	et of worl	kina	16b. k	Kind of Bus	siness/Ind	dustry	
	Elementary/Seco		st grade complete	(1-4or 5+)		life. D	O NOT use retire	ed)	J. OF WOLF	ung					
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ne combiered	17. Father's Name	(First, Middle,	Last)					1	er's Nam	ne (First, Middle,	Maide				
	พากา	am C.	Herron					1	Marv	Varney					
	19a. Informant's Na				101	Mailin	Address (Stree	!			or City	or Town	State 7in	Cada)	
1	Naomi He						Dunbro							,	
-			MITE		OOb Diser										
	20a. Method of Disp		3 ☐Removal fro	m State	cemete	ery, crem	ition (Name of atory or other pla	ice)		Date	20c. L	.ocation - (City or To	owп, State	
-	4 □ Donation			iii Otate	Stau	ffer	Cremato	ory	4/2	/2007	F	rede	rick,	, Mar	yland
İ	21. Signature of Fu	ıneral Service	Licensee			22.	Name and Addr	ess of Facil	lity S	Stauffer	Fu	nera	1 Hor	me	
ļ	Pront	nou) (Stand	000		155	1621 Ope	ssum	town	Pike, H	red	ericl	k, MI	D 217	02
+	23a Part1 Enter	ne disease of	complications in	ot caused th	ne death. Do		-							Approxim	nate
	23a. Part1. Enter of shock, or hea										1000,			Interval E Onset an	Between
ĺ	Immediate Cause (disease or conditio		_a. C	lreb	ro Va	SC V	lar	RCC	a, a	bont				/	no
- 1	resulting in death)				consequence										
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1	cause. Enter Unde Cause (Disease or that initiated events	injurý													
	resulting in death) I	Last	Due	to (or as a	consequence	of):									
INCORCAL			d												
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manager of a possession	23b. Was deceden in the past 12			e birth 2	Fetal death		Ectopic pregnand	су				23d. Date Mor	e of delive	ery Day	Year
	1 ☐ Yes 2 [□No	4□Pre 9□Un		me of death	5 🗌	Other (specify) _					IVIOI	141	Day	roai
	9 ☐ Unknown		\$1.011												
	Part II. Other signif	ficant conditi	ons contributing to	death but	not resulting i	in the un	derlying cause gi	ven in Part	l.	23e. Did to	obacco	use contr	ibute to th	he cause c	of death?
										1 🗆 '	Yes 2	2	3 ☐ Prob	bably 4	Unknown
										040 144-	on.	DAL I	Nors su	non fir di	no overlett
										24a. Was autor	osy) p	prior to con	opsy finding impletion o	gs available f cause of
										perfo 1∐ Yes	rmed?		leath? □Yes	2 🗆 No	
	25. Was case refer	red to medica	I					26. Plac	e of Dea	th (Check only o	nne)				
-	examiner? 1 ☐ Yes 2	No	Hospital: 1	☐ Inpatient	2 □ ER/O	utpatient	3□ DOA Ot	her: 4	orsing He	ome 5 Resid	dence	6 □Oth	er (Specif	fv)	
İ	27. Manner of Deat	th	28a. Da	te of Injury	28b.	Time of	28c. Inju		aroing ri	28d. Describe I				<i>y</i> /	-
ı	1 Natural	5 ☐ Pendir investi	ig .	onth, Day	Year)	Injury		ork?]Yes 2[1No						
ı	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could	not be	oo of injun	(- At home fr	arm etro	et, factory, office		91	20f Location //	Cérra a é a	an al Alexander	a v o v Duw	n I Bouto M	umbar -
1	4 ☐ Homicide	determ		ilding, etc.		ariii, Sire	et, factory, office			28f. Location (S City or Tox	vn, Stat	na ivumbe le)	er or Hura	ai Houte IV	umber,
-										<u> </u>					
	29a. Certifier (Check only	1 Certifyii	ng Physician: To Examiner: On the	the best of	my knowledg	e, death	occurred at the t	time, date a	and place	, and due to the	cause(s	s) and ma	nner as s	stated.	0(8)
	one)	ZLI Medical	and m	anner state	ed.		oonganon, miny	opinion, de		mou at the time,	uale al	iu piace, a	and due to	o nie caus	C(3)
	29b. Signature and	I title of certifie	r				29c. Licen	se number			29d. Da	ate signed	l (Month,	Day, Year)
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	30. Name and addr							. 3 . 1		MD 01700)				
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	31. Date filed (Mon	APR O	2 2007 32	. ogistrar	s Signatur	1	made .								
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Registrar

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Records, P.O. Box 68760,	The law requires that the death certificate be executed
or Vita	hysician:
Division or Vit	Hospital or Attending Pl
	Ξ ;

Physician /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 5. Social Security Number **Funeral** Director Usual Residence of Decedent 10a, State Director 28a-f 10e. Street and Number 23a or the Medical Examiner must be 1.2 should be filed within 72 hours after death v n and Mental Hygiene. is marked other than "natural", or items 23s Funeral 11. Marital Status Baltimore, Maryland 21215-0036 þ Completed 17. Father's Name (First, Middle, Last) ပ permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Barry Nordlinger / Son 20a. Method of Disposition **Physician** /Medical aminer Examiner attending physician and for use as the burial-transit Physician/Medical ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Director: After this certificate has been signed in by the funeral director, page 2 should be del þ Completed Be 25. Was case referred to medical examiner? P 27. Man of Death Certification: Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 tem 23a) (Type, Prigt)
860 | Vetergas Hishway Millorsville MD 21/08
gnature 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) KROM MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

07-02613	
Larry Charles Hall	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death April 5, 2007 LARRY CHARLES HALL. Year 1715 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Hospital Cheverly Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Aoe (In vrs. last birthday) **Funeral** 577-66-8464 Foreign Country) VA Min. 57 Months Days Hours 07/26/1949 Director 2 F Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10c. City, Town or Location 10b. Count MD Prince Georges Landover s 23a or 28a-f show e notified at once. 1 X Yes 2 No 28a-f show Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Jonquil Avenue 20785 USA <u>ख</u> 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. tant: Hitem 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 Yes Black 3 Widowed 4 Divorced If Yes, Give Year Yes 2X No specify: Specify <u>Ş</u> more, MD 21215-0036
Pages I and 2 should be filed within 72 hours a near of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Utility Clerk Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oscar Hall Margaret Proctor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharnee Hall 102 Jonquil Ave, Landover, MD Daughter 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Baltimore, 1 X Burial 2 Cremation 3 Removal from State Maryland National Mem Park 04/11/1007 Laurel, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service License 22. Name and Address of Facility Bianchi 814 Upshur St NW, Wash, DC 20011 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and (Viedical Death a Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transi sician/Medical X UNPENDED AMENDED, 27, perME, g866, 4/17/07 TI physician the burial sician Box 68760, IE FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth use as t Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available peen 24a, Was an prior to completion of cause of autopsy has performed? certificate page ✓ Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: director, Be of Vital Other₄ Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 1 A Natural Division 1 Yes 2 No 5 Pending 24 hours after death. the Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3 April 7, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31 APRILIPA (MONTO 2007 ear) 32. Registrar's Sig

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** BERNICE ELAINE JOPPY MARCH 27,2007 2:30 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital MONTGOMERY Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 219-34-9140 79 Director Mar.17,1928 Wash. DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State show 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director MD Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21000 Father Hurley Blvd 72 hours after death with 20874 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I and 2 should be filed within sealth and Mental Hygiene. Montq. CoSenior Elementary/Secondary (0-12) 12th College (1-4or 5+) Transportation Dispatcher Citizens Transp 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anderson Talley Esther Beal ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 I Melvin Joppy, Jr (Son) 15400 Pincherry Lane, Gaithersburg, MD 20878 20b. Place of Disposition (Name of Premetary, crematory, or other place Pleasant View Hastorical Cem permit. Pages 1 a
Department of Her
Important: If item
any Injury or othe 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from 4 Donation 5 ☐ Other (Specify) 4/2/07 Gaithersburg, MD 21. Signature of Funeral Service Licental 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part1. Enter the diseashock, or heart failur not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Fai Physician Respiratory mins disease or condition resulting in death) /Medical r as a consequence 1) **Examiner** Diabetes Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, nding physician use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 📉 No
9 ☐ Unknown 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) been signed by the should be detached Division or Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 si autopsy performed 1☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F s after death. Il Director: After d in by the funera Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours a e Funeral I TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

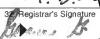
31. Pate filed (Month, Day, Year)

(Check only one)

29b. Signature and title

MAR 3 0 2007

SROUR



and manner stated.

nd address of person who completed cause of death (Item 23a) (Type, Print)

M. D.-9901 Medical Ctr.

			1 - State Registrar	State of Maryla		artment of I rtificate of			giene Reg. No.	007	11895	
	*	-	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ith Day	Year	3. Time of Death		
185	Physici /Medio		CHANEY AMELIA			JOHNSON	MARCH	27	2007	2:00 A M		
*	Examir		4a. Facility Name (If not institution, give street and number)			4b. City, Town,	eath	4c. (County of Death			
2			6719 DARBY ROAD			LANDO				PRINCE	GEORGE'S	
*	Funeral Director		182-40-0103	7. Age (In yrs 58	. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day 01/19/1	(Year)	Cou	place (State or Foreign ntry) HINGTON, DC	
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits	
	Mary	Funeral Director	MD PRINCE GEO	RGE'S I	ANDOVE	R HILLS					1 XYes 2 No	
	1 the		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?								ntry?	
	should be filed within 72 hours after death with the Maryland of Menial Hygene. marked other then 'naturel', or liems 23a or 28e-f ehow marked other then 'naturel', or liems 23a or 28e-f ehow marked other then 'naturel'.		6719 DARBY ROAD		20784			USA				
			11. Marital Status	Was Decedent Ever in the Armed Forces?		Was Decedent of I	Hispanic Origin?	(Specify Yes or No-	1	4. Race - Ameri Black, White,		
9	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 ŽNo If Yes, Give		Tes, specify Cuc		Jento Filoani, etc.)		Specify: BL		
Ö	urel'.	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:			to the state of Course of			16b. Kind of Business/Industry			
21215-0036	n 72 n nai	Completed	15, Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of t	working	16b. Kin	id of Business/Ir	idustry	
7	with iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)			·	סי	DD	TVATE		
ਰੂ	othe ent,	To Be C	17. Father's Name (First, Middle, Last)	TI CARL	Y CARE PROVIDER 18. Mother's Name (First, Middle)							
<u>Ja</u>	should be and Menta marked umatic ev		LAWRENCE T. JACKS		JUANITA ODOM							
Maryland	2 6 9 5		19a. Informant's Name/Relationship (Typ					Rural Route Numbe			Code)	
	1 and 2 Health tem 27		JUANITA ODOM/MOTH				LANDOV	ER HILLS,			20784	
altimore,	or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re	moval from State	cemetery, cren	sition (Name of natory or other pla		Date	20c. Loc	cation - City or T	own, State	
Ē.	t. Pa rtmen rtant:		4 Donation 5 Other (Specify)			CTION CEN		/3/2007 . B. JENK		NTON, MAI		
Ba	permit. Pages Depertment of It Important: If ite eny injury or of		21. Signatus of Fyrieras Source License	9				AD LANDOV				
	.80		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
	Physician /Medical Examiner	Iner	shock, or heart failure. List only one Immediate Cause (Final	SMALL BOW	EL CARC	CTNOMA					Interval Between Onset and Death	
			disease or condition resulting in death) a. Due to (or as a consequence of):									
47			Sequentially list conditions b.									
15			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
	icate be executed physicien and s the burial-transit	Examin	that initiated events c. resulting in death) Last									
8760	sicien buria	dicai E	Due to (or as a consequence of):									
9	g phy as the	d)	u.									
ŏ	eath certifi attending	M/us	IF FEMALE: 23b. Was decedent pregnant 23	Cotonio negana		23d. Date of		delivery				
. B	0 0	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	Ectopic pregnancy Other (specify)			Month Day Year					
J.	that the de led by the a detached	Physician/M	9 Unknown	9□ Unknown				40 8111				
က်	Attending Physician: The law requires that the redeath: redeath. ector: After this certificete has been signed by the tuneral director, page 2 should be detached the funeral director.	þ	Part II, Other significant conditions cont	iderlying cause gi	ven in Part I.		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※Unknown					
Ö		etec										
Records ,		Completed						24a. Was a autop:	SV	24b. Were auto prior to co	ppsy findings available impletion of cause of	
_			25. Was case referred to medical					1 ☐ Yes	2 <u>√</u> No	1 ☐ Yes	24☐ No	
Vita		Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2\mathbb{X} No									
			27. Manner of Death	28c. Injury at Work? M 1 Yes 2 No			28d. Describe how injury occurred					
Ö			27. Manner of Death 1									
Division	of or Atterder de I Directed	rtific	3 Suicide 6 Could not be determined			28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
2	olfet o urs af arel D	ledicai Cer										
	To the Hospitet or Ai within 24 hours after of To the Funerel Directompletely filled in by		29a. Certifier (Check outy one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check outy one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the within 2 To the complet	Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								Day, Year)	
		maran O. Welten						707/0			2007	
	(6)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						MARCH 30, 2007			
- (6		MARTIN D. WELTZ	M.D. 7525 GI	REENWAY	CENTER	DRIVE SU	UITE 205 (REEN	BELT, MA	RYLAND 2077	
1	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature							

an Allen	Johns		State 1- For State Registrar	of Maryland / Depa Cea	artment of rtificate of		and	Menta	ıl Hyg		g. No.	200	/ 11897
	hysici	an/	1. Decedent's Name (First, Middle,Las						2	Date of Deat Month		Year	3. Time of Death
vical l	Exami	ner	VAN ALLEN JO							April 6, 20	07		1601 hrs
			4a. Facility Name (if not institution, given 8255 Landonderry Court	ve street and number)	4	b. City, Tov Laurel	vn, or Lo	cation of (Death			ounty of Deat	Í
	ıneral		Social Security Number 6. S		ast birthday)	If Under		If Under 2		8. Date of Birt	h(MM /DE)/YYYY) 9. Bi Forei	rthplace (State or
Dir	rector		220-88-530 B ₁	Xм 2⊡F 4	4 Yrs.	Months	Days	Hours	Min.	1-2-	1963	} C	ountry) MD.
	ý		Usual Residence of Decedent 10a. State 10b. County	40- 0:4:	Town or Location			•					10d. Inside City Limits
	w any			GEORGES		LAURI	PΤ.						1 X Yes 2 No
yland	28a-f show 1 at once.	호	10e. Street and Number	GEORGED		10f. Zip Ci				110	na Citizer	n of What Cou	
e Mar	23a or 28a-f sho notified at once.	Director	8255 LONDONDI	ERRY COURT)70°	7				5.A.	
vith th	s 23a e notif		11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was				? (Spec	ify Yes or No-			ican Indian, Black,
eath v	item ust b	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 Y No		es, specify (White, etc.	
ıfter d	l", or	by F	3 Widowed 4 Divorced	If Yes, Give Year	1	Yes 2	No a	specify:			Sp	pecify: W	HITE
ours a	xami		15. Decedent's Education (Specify o	only highest grade completed)	16a. Decedent	st of working					16b. Kin	d of Business	Industry
36 n 72 l	ical E	Set	Elementary/Secondary (0-12) 1 2	College (1-4 or 5+) 1yr.college							FYD	O DEC	IGN CENTER
215-0036 be filed within 7	Aental Hygiene. narked other than event, the Medical	Completed	17. Father's Name (First, Middle, Last		DEI I.					irst, Middle, N			IGN CENTER
215 e filed	tal Hy ced of nt, th	BeC	•	NATIUS JOHNS	SON					GNES		,	
21; ould b		2	19a. Informant's Name/Relationship (19b. Mailing		(Street a	ind Numbe	er or Rui	al Route Num	ber, City	or Town, State	
; MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	nt of Health and Mental Hygiene. t: If item 27 is marked other than other traumatic event, the Me ical		JULIE ALPER									20646	
. 6	f Hea If iten er tra		20a. Method of Disposition 1 X Burial 2 Cremation 3	20b.	Place of Disposi crematory or oth	tion (Name er place)	of ceme	tery,		Date -		cation - City or	
imore Pages 1	nent o									2-07		GAH,M	D•
Baltimore,	Department of Important: injury or otl		21. Signature of Funeral Service Licer	nsee MOO4 79	22 N R		dress of	- UNE	RAL	SERVI 646	CE,	P.A.	
		_	23a. Part I. Enter the disease, or com	nligation that caused the death	Donot enter th	A PLA	A'I'A	, MD .	Z O	646	et shock	or heart	Approximate Interval
	sician edical		failure. List only one cause on e	A crobyreria	. Do dot cintor th	io mode or c	.yg, 00	or as said		oop, a.o., y a.o.	, one on	, or mount	Between Onset and Death
Exa	miner		Immediate Cause (Final disease or condition resulting in death)	Asphyxia Due to (or as a consequence of	of):						_		+
			Sequentially list conditions, b										
		ie	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	of):								
1		Examiner	(Clause or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):								
executed	and transi		d	. <u> </u>							_		
	sician and burial - tra	edical	X UNPENDED	AM#23a,27,28a-f,	perME, g	868 , 6/	/11/0	7 TT_					
Box 68760,	the attending physned for use as the br	N/	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy	tal death		Ectopic p	regnand	ev		Date of deliver onth	Day Year
x 68	tendin use a	sician/M	past 12 months?	4 Pregnant at time of de	- L	ner (Specif)]=0.001.0 P		,			
Bo.	the at ed for	Phys	1 Yes 2 No 9 Unknow	9 Unknown						Tan and			11
n of Vital Records, P.O. Box 6876 ding Physician: The law requires that the death certificate	signed by the	by P	Part II. Other significant conditions	contributing to death but not	esulting in the u	nderlying ca	ause giv	en in Part	I.				the cause of death?
S, F	en sigr ald be									24a. Was a			utopsy findings available
ord aw rec	has been s 2 should	ompleted								autop			completion of cause of
Rec	icate l	Con								1 🗸 Yes		1 🗸 Y	es 2 No
cian:	his certificate director, page	Be (25. Was case referred to medical examiner?	Hospital:] 50/0: ttit		10	f Death (C			Dasidana	ce 6 🗸 Othe	or: Scana
of Vi	er this ral dir	မ	1 Yes 2 No 27, Manner of Death	28a. Date of Injury	ER/Outpatient		`	at Work?		8d. Describe h			er, goerre
on o	th. r: After t e funeral	ion:	1 Natural 5 Pending	(Month, Day, Year) Fnd 4/6/2007	Fnd 3:45		1 Ye	s 2 X N	lo :	plastic	bag o	ver head	
Division of Vital Records,	er death rector: by the	icat	2 X Accident Investiga 3 Suicide 6 Could no	28e Place of Injury - At h			ffice bui	lding, etc.					ural Route Number, City
	ours after reral Dir filled in	Certification:	3 Suicide 6 Could no determine		ce				8	255 Land	onder	ry Ct. L	aurel, MD
Hosp	within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physic	cian: To the best of my knowled	dge, death occur	red at the ti	me, date	and place	e, and d	ue to the caus	e(s) and	manner as sta	ited.
ro the	within 24 h To the Fur completely	Medical		er: On the basis of examination and manner stated.	and/or investigat				irred at f	the time, date			
	-,- 3	Ž	29b. Signature and title of certifier	1 11/	,		icense					ate sign e d <i>(M</i> 7, 2007	onth, Day, Year)
			V- 1	W. It			O.C.M				Typiii	,, 2007	
K			30. Name and address of person who Jack Titus MD. Deputy	completed cause of death (Iter Chief Medical Examine		n Street	Baltir	nore. M	D 212	01			
-0			31. Date filed (Month, Day, Year)	32 Registrar's Signal		M R-		,					

Registrar

			1 - For State Registrar	State of M	/laryland		artment of rtificate o				giene Reg. No.	007	-	398
			1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea		Year	3. Time o	f Death
	Physici /Medi		Rev	. James P.	Kelly,	0.S.	F.S.			April	6	2007	1715	P^{M}
	Examir		4a. Facility Name (If not institution	, give street and number	nr)		4b. City, Town	or Location	of Death		4c. Co	unty of Death		
			Annecy Hall				Child				Ce	ecil		
	Funeral	î.	5. Social Security Number	6. Sex 7. / 1 M 2 □ F	Age (In yrs. last	,,	If Under 1 Yea Months Day		Min.	8. Date of Birt (Month, Da	y, Year)	Cou	place (State ontry)	
	Director		184-22-6973 Usual Residence of Decedent	8	30	Yrs.				JAN 20,	1927	Pen	nsylva	<u>nia</u>
	and and		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside C	ity Limits
	Mary	ō	Maryland Ceci	1	Chi	ilds							1 🗌 Yes	2 ∑ No
	28a	rec	10e. Street and Number	- .	CIL	LIUS	10f. Zip Code				10g. Citizen	of What Cou	ntrv?	
	With No.	<u> </u>	1120 Blue Ball	Road			2191					ited St	•	
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow he Medical Expriner must be notified at	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13.	Was Decedent of f Yes, specify Ci		rigin? (Sp	ecify Yes or No		Race - Amer	can tndian,	
(0	riter	들	1 X Never Married 2 ☐ Marr	Armed Force		1				Rican, etc.)		Btack, White	etc.	
8	ai', o	ě	3 Widowed 4 Divorced	tf Yes, Give Year or Dates	s:		1□Yes 2∏XN	o Specify	y:		Sp	ecify: Wh:	ite	
21215-0036	72 ho	Completed	15. Decedent (Specify only highes		11	6a. Dece	dent's Usual Occ	upation	st of work	ına	16b. Kind	of Business/Ir	ndustry	
21	thin	츌	Elementary/Secondary (0-12)	College (1-4o	r 5+)		kind of work dor DO NOT use reti			9				
2	ygien ygien t. th	ပြွ		5+		Pr	iest/Lil					igious		
Maryland	12 should be filled within in and Mental Hygiene. 7 ie marked other than "treumatic event, tha Mac	Be	17. Father's Name (First, Middle,	Last)						e (First, Middle,	Maiden Su	mame)		
<u>ya</u>	Men Men Merke Marke	ြ	Thomas Kelly						ra Dı					
Mar	2 sh and i and reur		19a. Informant's Name/Relations				ng Address (Stre						-	
	togs 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural; or items 23s or 28s-f show or other freumatic event, the Madical Examinar must be notified at		Oblates of St. F	rancis de Sa			Kentmere)6
0	Pages 1 nent of H int: If ite		20a. Method of Disposition 1	3 Removal from Star	te ceme	atery, crer	natory or other p	lace)	Apri	l ^{at} 10,	20c. Locat	ion - City or T	own, State	
ij	tmen tant:		4 Donation 5 Other (S		0bla		emetery		2007			s, Mar	yland	
Baltimore,	permit. Pages 1 and 2 of Depertment of Health at Important: If Item 27 ie eny injury or other treu QDGs.		21. Signature of Funeral Service	S. Herr		Hi 10	Name and Add Cks Home 3 W. St	ress of Faci e for ockton	Fune: Str	rals, P eet, Ell	.A. kton.	Marvla	ind 219	921
	-		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the death. D						The second secon		Approxima Interval Ber	te
4	Physician	ļ.,	Immediate Cause (Final disease or condition	C	200000	. A	Acc.	Disca	80				Onset and	Death
7	/Medical		resulting in death)	Due to (or a	as a consequent		17	01200	-				<u> </u>	7010
	Examiner		Sequentially list conditions,	I, F	ailur	- 40	Thri.	ر					140	2
7	ם ≃	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequen	ce of):								
N	acute	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.										
30,	e exc den a	0	1630 (alg III Gea(II) Last	Due to (or a	as a consequent	ce of);								
8760,	cate be executed obysicien and the burial-transit	dical		d							-			
9		Me	tF FEMALE:	020 11.00										
Box	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea	ath 3□	Ectopic pregnar	ісу			23d	. Date of deliv Month		Year
	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant 9□ Unknown	at time of death	1 5	Other (specify)						,	
P.0	that the ded by the detached	P	Part II. Other significant condition	ns contributing to death	but not resultin	n in the u	nderlying cause i	uven in Part		23e Did to	obacco use	contribute to	the cause of o	death?
ds,	ires tha signed d be det	Completed by	, and an an an an an an an an an an an an an		. Dat Hot Toolikii	9 117 (110 (1	iddifyllig oddoo ;	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 🗆)			bably 4 □	
Ö	w requir been s	etec												
360	elaw hasi	Ig I								24a. Was autop		4b. Were auto prior to co death?	opsy findings ompletion of a	available ause of
<u>a</u>										1 ☐ Yes	2 No	1 🗆 Yes	2 No	
Vital Records,	Physician: The this certificete har all director, page	Be	25. Was case referred to medical examiner?	Hospitat			- 10	thor		h (Check only o				
4	Phys this ral di	<u>유</u>	1 Yes 2 No 27. Manner Death	1 ☐ Inpa		Outpatier b. Time of	, and box	401		me 5 Resid			fy)	
	ding l	5	1 ☑Natural 5 ☐ Pendin	g (Month, L	Day Year)	Injury	W	ork? ☐Yes 2.[Zou. Describe i	iow injury or	æurreu		
isi	Ntendi death. ctor: A y the fu	cal	3 Suicide 6 Could r	not be 300 Place of I	niun, - At home	farm etc	eet, factory, offic			28f. Location (5	Street and N	umber or Rus	al Poute Num	n hor
Division	after Direct	Certification:	4 Homicide determ	building,	etc. (Specify)	, 10,1111, 31,1	eet, ractory, onle	•		City or Tox	vn, State)	umber or riur	ar moore wor	1201,
_	ours ours nerel filled		29a. Certifier 1 Certifyin	g Physician: To the be	st of my knowled	dge deat	occurred at the	time date a	and place	and due to the	causa(s) an	d manner as	stated	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	Medicai	(Check only 2 Medicat one)	Examiner: On the basis and manner	of examination	and/or in	estigation, in my	opinion, de	ath occur	red at the time,	date and pla	ice, and due	o the cause(5)
	ro th vithin ro th	Me	29b. Signature and title of certifier	1 1 11	0		29c. Lice	nse number			29d. Date s	igned (Month,	Day, Year)	
	- > - 0		> 6h .	CK Ha	الم	10	DE	Capo	N 55	210	A	19	2007	
	M		30. Name and address of person	who completed cause/or	f death (Item 23	a) (Type		L all	رد بر	200	1 1PM	1 1		
	10		Christine E	K. Horah	00	4	2 Subjack	in p	laza	New	alk	Dela	war 1	17711
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	1	20.000		'					
	Registi		APR13	2007 Jan	w B.	Spa	الناكية							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Yea 07 04 08 0427 М William . Koelle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS Braddock Campus Allegany Cumber land If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 24, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days PA 1 M 2 □ F 219-44-0031 60 1946 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD 1, Yes 2 No Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 901 Braddock Road 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wash, Co. Bd. of Ed. quidance counselor 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irvin Samuel Koelle Elizabeth Clossin Koelle ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12712 N. Cresap Street Cumberland MD 21502 Linda Valentine sister Department of Health Important: If item 27 any Injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4/12/2007 MD LaVale 4 □ Donation ⊃5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, phocy, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im edial. Cause (Final disease r condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physiclan: The law requires that the death certificate be executed Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown DISORDER 1 Tes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has the irector, page 2 s autopsy performe 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

State

National Highway Lavale Maryland 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

31. Date filed (Month, Day, Year)

APR 13

			1 = For State Registrar	State of N	Marylan	•	artmen <i>tificati</i>			and N	lental Hyg	iene	07	11900
	_		1. Decedent's Name (First, Middle, Last)								2. Date of Deat Month		Vear	3. Time of Death
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	Examir		4a. Facility Name (If not institution, give s				•		Location o	f Death		1	y of Death	
			Glen Meadows Nursi					n Arn				Balt	timor	e
	Funeral		5. Social Security Number 6. Sex	M 2 🗐 🕌		last birthday)	If Under Months	1 Year Days	If Under :	Min	8. Date of Birth (Month, Day, Feb. 27	Year)	9. Birth	place (State or Foreign intry) y Land
	Director		220-34-0004	ZX	92	Yrs.					Feb. 27	, 1915	Mar	yiand
	and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
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	the 28a	reci	10e. Street and Number		010	-11 411111	10f. Zip	Code			1	0g. Citizen of	What Cou	ntry?
	a with		11630 Glen Arm Roa	d Apt.	#211			1057				U	S.A.	
	72 hours after death with the Maryland Insturel', or teme 23a or 28e-f show Jisel Evald we most be redified at	Funeral Director				.S. 13. \	Nas Deced	lent of His	spanic Orig	gin? (Sp	ecify Yes or No- Rican, etc.)		се - Алтеп	
9	after or Ite	Ē	1 Never Married 2 Married	2. Was Deceder Armed Force 1 Yes 2	s? MNo		tYes,spec 1 ∐ Yes 2			, Риепо	Hican, etc.)		ack, White,	etc.
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121	within iene. than	ldm	Elementary/Secondary (0-12)	College (1-40	or 5+)		DO NOT us			_		Mara		
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anc	ntal hed of	Be	Lewis W. Putman								Summers		1110)	
Ž	hould d Me mark mark	2	19a. Informant's Name/Relationship (Typ	o Print)		10h Mailin	a Address	/Street a			al Route Number		State Zi	Code)
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Baltimore,	그 문문를		21. Signature of Funeral Service License	-		22	Namean	d Addres	s of Facilit	y, c	SON FUNI			
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	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):								
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Ulsease or injury	Due to (01 a	as a consequ	derice orj.								
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XO	leath certifica attending pla if for use as t	an/N	23b. Was decedent pregnant	3c. If yes, outcom 1 ☐ Live birth			Ectopic pr	egnancy					ate of deliv	,
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ion	Attending F r death. ector: After by the funer	atlo	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigation	(MORUI, L	Day Year)	Injury	М		es 2□ì	No				
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	4		30. Name and address of person who cor	agen	16	5701	<i>N</i>	CHI	MU	35	ST !	MILIM	ORE	21204
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			Registrar		C	ertificate of	Death			Reg. No.	97 1901
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	/Medic				alabokes				darch		7:45 a M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of	of Death		4c. County of	Death
	<u> </u>		15210 Elkridge V				er Spr	ing	D		ntgomery
	Funeral		5. Social Security Number 6. Se 578-24-2845	ex	Age (In yrs. last birthda 84 Yrs.	y) If Under 1 Year Months Days	Hours	Min.	Date of Birth (Month, Day	/, Year)	9. Birthplace (Štate or Foreign Country)
	Director		Usual Residence of Decedent	x	04118			\$e	pt. 19	9, 1922	Florida
	and * :		10a. State 10b. County		10c. City, Town or	Location	-				10d. Inside City Limits
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	the A	ect	Maryland Mont	gomery	۵	ilver Spr	ing			10a. Citizen of Wh	nat Country?
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	s 23	Funeral Director	15210 Elkridge Wa	12. Was Deceder		Was Decedent of I	209		Voc or No	U.S.	American Indian.
	ltem ner r	ů.	11. Maritai Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	1 Ever III 0.3.	B. Was Decedent of F if Yes, specify Cub	an, Mexican	i, Puerto Ric	an, etc.)	Black,	White, etc.
36	's aft	by F	3¥☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2√☐ No	Specify:			Specify.	Mhite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	ba	15. Decedent's Ed			cedent's Usual Occur	nation			16b. Kind of Busi	ness/industry
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Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show it item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at) Be	James Milton Ho			Sı	ıe Alb				
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07-02264 Adel Kagan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Adel Kagan	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2007	1190
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death	3. Time of Death 1100 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Rockville 4c. County of Death Montgomery	<u> </u>
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth	
any		10d. Inside City Limits
-f show once.	MD Montgomery Rockville	1 Yes 2 No
the Maryland a or 28a-f sh tified at onc	10e. Street and Number10f. Zip Code10g. Citizen of What Country262 Congressional Lane #10220852United State	-
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any rother traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2	an Indian, Black, White
cours aftural" xamine	Specify: Specify: Specify:	
5-0036 fed within 72 hour 1/19giene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Engineer Government	
21215-0036 Juld be filed within 7 Mental Hygiene marked other than re event, the Medica To Be Comple	Moshe Kagan Emma Smusine	
MD 21 nd 2 should alth and Me m 27 is man aumatic ev	19a. Informant's Name/Relationship (Type, Print) Alexander Gorodetsky- Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 1708 Mark Lane Rockville MD 20852	Zip Code)
Baltimore, MI permit Pages and 2 s Department of Health a Important: If item 27 injury or other traum	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Garden of Remembrance Memorial Park 20c. Location - City or To crematory or other place) Clarksburg	
Ball permit Depart Impor injury	21. Signature of Euneral Service Licensee 22. Name and Address of Facility Edward Sage1 Funeral 1091 Rockville Pike Rockville MD 2085	Direction
Physician Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Approximate Interval Between Onset and Death
	Sequentially list conditions, b	
ted Insit Examiner	If any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
s0, te be executed ysician and burial - transit	d. AMENDED	
760, cate be execut physician and the burial - tra	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
D. Box 6876 the death certificate by the attending phy ched for use as the I Physician/M	23b. Was decedent pregnant in the past 12 months? 1	y Year
i, P.O. B rires that the d signed by the be detached d by Phy	1 Yes 2 No. 3 Probat	e cause of death?
cords law requi	24a. Was an autopsy prior to cor death? 1 ✓ Yes 2 No 1 ✓ Yes	psy findings available npletion of cause of
Vital Recognistics of the conficute director, page	25. Was case referred to medical examiner? Hospital:	Scene
on of Vi nding Physi th r: After this re funeral dir ion: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No Subject scalded in hot water	Joshic
Division of Spirition of Spirition of Spirition of Mours after death Hours after death Filter of Spirition of	Accident Investigation Mar 24, 2007 1025 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State) 262 Congressional Lane, Rockville, No. 265 Congressional Lane, Rockville, No. 266 Congressional Lane, Rockville, No. 267 Congressional Lane, Rockville, No. 268 Congressional Lane, Rockville, No. 269 Congres	
To the Hospital within 24 hours To the Euteral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated.	
3	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) O.C.M.E. March 25, 2007	n, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 03-27-2007 9:10 A M EMANUEL LEE LOGAN, SR. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GREATER LAUREL REHAB. & NURSING CENTER Prince George's Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year 07-11-1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral €** 2□ F Yrs Dillwyn, VA. 578-01-8070 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits or tems 23a or 28a-f show then may be notified at 1 ¥ Yes 2 No Director Laurel Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 11204 Evans TRail #103 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. or Items Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after it Hygiene. other than "natural", or ite 1 EYes 2 No ff Yes, Give Year or Dates: 1943 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black r than "natural", o þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/fndustry Elementary/Secondary (0-12) College (1-4or 5+) Private Industry maintenance 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) un-avail. William Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11204 Evans Trail #103 Beltsville,Md. 20705 Thelma L. Logan/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 to Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem 04-02-2007 Cheltenham, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary Hedgman MU137 Cedar Hill FH 4111 PA Ave. Suitland, Md. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** 1 Day Pulmonary Embolism /Medical Due to (or as a consequence of) Examiner COPD Exacerbation 2 Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ettending physician and for use as the burial-transit The law requires that the death certificate be executed 2 Years Heart Block that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🐼 No 9□ Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Dementia 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hypertension autopsy performed? 1 ☐ Yes 2 ☐ No certificete 1 Yes 2 No Division of Vital the Hospital or Attending Physicien: director 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No М investigation Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after within 24 hours a
To the Funeral I
completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ATTENDING 29c. License number 29d. Date signed (Month, Day, Year) ture and title of certifier 29b. SigN months physicina D0057216 MAIZCH 29, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Baako, MD 14200 Laurel Park Drive Laurel, Maryland 20707 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State APR 0 2 2007 Registrar

		1 - For Stete Registrar	State	of Maryla		artment of H		ind Me		jiene leg. No.	007	119	04
		1. Decedent's Name (First, Midd	le, Last)					1	2. Date of Dea Month		Year	3. Time of	Death
Physic /Med		R	oby Carme	n McCra	W				April	6	2007	2300	РМ
Exam		4a. Facility Name (If not institution				4b. City, Town, or	Location of	f Death		4c. Co	unty of Death		
		Laurelwood C				Elktor	1 If Under 2	24 Hrs. I	0 D-1 1 B:-11		Cecil	-1 (0)-1-	
Funera		5. Social Security Number	6. Sex 1 🕅 M 2 🗆 F		s. last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day		Cou	place (State o	r Foreign
Directo)r	219-16-5803 Usual Residence of Decedent		89					March 31	, 1910	VII	ginia	
yland		10a. State 10b. County		10c. C	City, Town or Lo	ocation						10d. Inside Cit	
e Mar	ctor	Maryland Cec	il .		E1kton							1 🗌 Yes	2 💢 No
ith the Marylar or 28a-1 show	Director	10e. Street and Number				10f. Zip Code			1	10g. Citizer	n of What Cou	intry?	
ath w		1010 Union C				21921					ited St		
er de	Funeral	11. Marital Status	Armed F		U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Orig in, Mexican,	gin? (Spec , Puerto R	cify Yes or No- tican, etc.)	14.	Race - Amer Black, White		
rs aft	by F	1 Never Married 2 Mai	If Yes, G	2 🐧 No live Dates:		1 ☐ Yes 2🎇 No	Specify:			Sp	ecify: Wh:	ite	
2 hou	ed	15. Decede	nt's Education			dent's Usual Occup				16b. Kind	of Business/li		
Pin 7.	pie	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	life.	kind of work done of DO NOT use retired	during most ()	or working	9				
og will	Completed	2			P11	umber						Govern	nent
be file	Be	17. Father's Name (First, Middle	Last)				_	_	(First, Middle,	Maiden Su	mame)		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show raumatic event, the Medical Examinator ust be notified at	2		Lie Office British		401 14.77	A / 1 / (2)			hnson	- O:T	C 7	- Codel	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinating must be notified at		19a. Informant's Name/Relation Carmen Coulb		ahtar		ng Address <i>(Str</i> eet a Union Chu							
1 and Health Health tem 27	1	20a. Method of Disposition	ourne, Dau	20b.	Place of Dispo	sition (Name of		Da	ate		tion - City or T		
Pages nent of h		1 X Burial 2 ☐ Cremation 1 Donation 5 ☐ Other (State Ch	cemetery, crei nerry H	matory or other place	(9)	Apri1 2007		horr	U:11	. Maryl	and
permit. F Departme Importar any injur	ė	21. Sign ture of Funeral Service		Me	thouis	Cemeter Name and Addres	-				y IIIII	, raryr	anu
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7		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the dea							2011-03-03-03	Approximate Interval Bet	e ween
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/Medica Examine	_	resulting in death)	Due to	o (or as a conse	equence of):	- 1)						
Lxamme		Sequentially list conditions,	b. —	(or as a consc	ND >	TAGE L	EM	Ser.	7				
led /	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4	for as a conse	schienne or)								
be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a conse	equence of):								
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tificate	Medi	1.555.00.5											
death certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		Ectopic pregnancy				230	. Date of deliv		/nn/
e dea he att	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of		Other (specify)					Month	Day 1	rear
that the de ed by the detached	Phy	Part II. Other significant condit	ione contributing to	death but not re	sculting in the u	ndarkina causa anu	on in Part I		23e Did to	hacco use	contribute to	the cause of d	eath?
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sician: Th certificate rector, pag	ပိ	25. Was case referred to medical					26 Place	of Death	1 Yes	2 No	1 □ Yes	212 No	
Physician: This certificated for all director, it	0	examiner? 1 ☐ Yes 2 ☐ NO	Hospital:	Inpatient 2[☐ ER/Outpatier	nt 3 DOA Othe	an -	_	e 5 ☐ Resid		Other (Spec	ify)	
g Phys ter this	i i	27. Manner of Death	28a. Date	a of Injury onth, Day Year)	28b. Time o	f 28c. Injun	v at		8d. Describe h			,,	
endir eath. or: Af	ertification:	2 - 100100111	igation			M 1 🗆		-					
or Att	riff	3 Suicide 6 Could 4 Homicide deter	nine d 80. Plac	ce of Injury - At ding, etc. (Spec	home, farm, sti cify)	reet, factory, office		21	8f. Location (S City or Tow	treet and ∧ n, State)	lumber or Ru	al Route Num	ber,
pital ours a surs a sral C	O	20a Carifina 1 Partieu	L Shudsian To W	a bast of multi	nowlodes dost	b accurred at the time	- data a-	d plana las	- d dua to the a		4	atata d	
24 ho Fun	Medical		ng Physicien: To the Examiner: On the and ma)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title of certific	/			29c. Licenso			1		igned (Month	-	
->-0)				DS	4073	3		09 A	KPR 07		
10		30. Name and address of person	who completed car	use of death (ite	ет 23а) (Туре,	Print)				1 /		DE C	
(0)		ARIEN S	LOVE IN	Ω		CHVRCHM	gus	OZR		406	457LE	DE C	1720
* S	state	31. Date filed (Month, Day, Year	2007	Registrar's Sign	nature	200							

	Plea	se Type or Prir	nt in Bla	ck In	delible Ink.	Ensure A	II Copies	Are Leg	ible.	
	For	State of Ma	aryland /			lealth and N	lental Hy	giene	776 874 7	
	1 - State Registrar			Cei	rtificate of	Death	1	Reg. No. 2	197	11905
Physician	Decedent's Name (First, Middle						Date of Dea Month	Day	Year	3. Time of Death
/Medical	Ruby Marguer:				AL OIL T	. Ition of Dooth	March	28,		
Examiner	4a. Facility Name (If not institution Civista Mo 5. Social Security Number	lical Ce	nter		La Pa	Location of Death	8. Date of Birt	CI	of Death	.es
Funeral Director	217-32-1433	6. Sex 7. Ag	e (In yrs. last 3	Yrs.	Months Days	Hours Min.	Jan. 3	v. Year)	Con	place (State or Foreign ortry) cyland
M +	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				Ţ.	10d. Inside City Limits
a-f sho iffed a	Maryland Cha	arles	Marb	ury						1 ☐ Yes 🏖 No
ms 23a or 28a-f show r must be notified at neral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of		ntry?
is 236 must eral	4785 Bicknel	L ROAG 12. Was Decedent	Ever in IIS	12 \	20658		posify Voe or No		ce - Americ	can Indian
or ite	11. Marital Status 1 □ Never Married 2 □ Marri 3 □ Widowed 4 □ Divorced	Armed Forces?		- 1	f Yes, specify Cuba 1 □ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ack, White,	etc.
natural", lical Exa	15. Decedent	's Education	1		dent's Usual Occup	ation during most of work	ina	16b. Kind of E	Business/In	dustry
Hygiene "nature then then medical Ent, the Medical E	Elementary/Secondary (0-12)	College (1-4or 5		life. L	DO NOT use retired carian	i)	9	Colle	eae	
ther ther the Co	17. Father's Name (First, Middle,	Last)		птот	arian	18. Mother's Nam	e (First, Middle,			
Mental H arked oth atic even		Speak	e			Netti	, ,		Clar	k
and M is mar aumat	19a. Informant's Name/Relations	-	1			and Number or Rui				
m 27 in	Nancy L. Hob	son Daught				k Dr.,				
or off	20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation				sition (Name of natory or other plac	al Gard	Date 2,2007	20c. Location		·
artme ortant injury	4 ☐Donation 5 ☐ Other (S ₁ 21. Signature of Funeral Service		Tri	22	2. Name and Addre	ss of Facility		110220		Maryland
any and once			00668	Ι τ.	tilliam o	Funces	l Home	P.A	Hoad	20640
	23a. Part1. Enter the disease, or shock, or he in failure. List	complications that caused	the death. D	o not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	IIE at	Approximate Interval Between
hysician	disease or condition	2		Res	triction	e lung	diseas	re	,	Onset and Death
/Medical xaminer	resulting in death)	Due to (or as	a consequen	ce of):	Kypho	sis.				Years.
ine	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequent	te of):						
cian and ourial-transit	that initiated events resulting in death) Last	c Due to (or as	a consequen	ce of):						
		d		,-						
g phy as the		U.					_			
d by the attending physicisteached for use as the bu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3□	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
be d	arch. Other significant condition	ons contributing to death b			nderlying cause giv	en in Part I.	23e. Did to	1/		he cause of death?
beer shou							24a. Was	an 24b	. Were auto	ppsy findings available
cate has been s page 2 should							autop perfo		prior to co death?	mpletion of cause of 2 □ No
ertific sctor, Be (25. Was case referred to medical examiner?					26. Place of Deat				
this cal dire	1 ☐ Yes 2 No	Hospital:		Outpatien		4 Li Nursing Ho	ome 5 Resid			fy)
h. After funer fion:	27. Manner of Death 1 Anatural 5 Pending investig		y Year)	b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	low injury occu	irred	
rs after death. ral Director: After led in by the funer. Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determ	ot be 28e. Place of inju	ury - At home, c. (Specify)	, farm, str	eet, factory, office		28f. Location (S City or Tow		ber or Run	al Route Number,
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Compl	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best Examiner: On the basis o and manner sta	f examination	dge, death and/or in	n occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the rred at the time,	cause(s) and n	nanner as s	stated. to the cause(s)
within To th compl	29b. Signature and title of certifier		und		29c. Licens			29d. Date sign		
	30. Name and address of person Ravinder Since 31. Date filed (Month, Day, Year) MAR 3	who completed cause of d	eath (Item 29	a) (Tvne	D-C	01614	2011	Mar	Ch 2	8 14, 2007
B16	Ravinder Sino	lhwani 16	350	Pemk	DROOK S	o. Wa	LLdo R	F. md	.20	603
State Registrar	31. Date filed (Month, Day, Year) MAR 3	0 2007 32. Resistr	ar's Signature	K A	hod	•		,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** MARCH 29, 0410 FRANCIS MARUSAK 2007 MICHAEL /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UNION HOSPITAL ELKTON CECIL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XX 2 □ F Yrs. Director 176-16-9959 87 09/23/1919 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at to Yes 2 No Director NEW CASTLE NEWARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 920 ROCKMOSS AVENUE 19711 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: À Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR HOSPITAL/HEALTHCARE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ ANDREW V. MARUSAK MARY BRETSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a DOROTHY R. MARUSAK/WIFE 920 ROCKMOSS AVE., NEWARK, DE 19711 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State DELAWARE VETERANS Injury or permit. Page Department of Important: If any Injury or 04/02/2007 BEAR, DE MEMORIAL CEMETERY 21. Signature of Europal Service Con SPICER-MULLIKIN FUNERAL HOMES 1000 N. DUPONT PKWY., NEW CASTLE, DE 19720 23a-Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Recurrent /Medical Examiner CLEMIC 5 Cadio MGO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit the death certificate be executed OFDUM that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 ician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö Year in the past 12 months? Month Dav 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. the Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed KRNA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 phpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? al or Attending Plas after death. 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier 153510 MAVCH 29 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) i Moth 70 1160 31. Date filed (Yehth, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 007

							Certific	cate of	Death)		Reg. No).	J 1	
		1. Decedent's Name (First	t, Middle, Li	ast)							2. Date of De	ath		Vana	3. Time of Death
2	Physician		CE	VICTO	RIA	MULC	SREW				Month	29	, 20	007	1:12 AM
1	/Medical Examiner	As Essite None Ment		ve street and nu	mber)				4b. City, To	own, or L	ocation of Deet	h 4c		of Death	
1	Examine	McCready Me							Cri	sfie	ld.			Somer	set
9		5. Social Security Number		Sex	7. Age (In yr.	e lact hirth	davd If L	Jnder 1 Year				rth .			
	Funeral			1□M 2XF		v.	Mor	nths Deys		Min.	8. Date of Bir (Month, Da	y, Year)	Coun	lace (State or Foreign try)
	Director	146-12-5184 Usuel Residence of Dece	dont		95						June 8,	19.	LI	New	Jersey
	pue *		County		10c. (City, Town	or Location	1						1	0d. Inside City Limits
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	death with the Meryland ms 23a or 28a-f ahow r.must be notified at ners! Director	10e. Street end Number					10	f. Zip Code				10g. Ci	tizen of V	Vhet Coun	try?
	23a		Stree	et. – Apa	rtment	23		2	1817				U	SA	
		11. Marital Status		12. Wes Dec	edent Ever in	U,S.	13. Was D	ecedent of l	Hispanic Or	rigin? (Sp	ecify Yes or No Rican, etc.))-		e - Americ	
0	efe of a second		Married	1 ☐ Yes							ritioan, oto.,				
8	S L	3 ☑ Widowed 4 □ D	ivorced	Year or D	ve letes:		1 🗆 🕶	es 2∭ No	Specify	•			Specify	. Whi	ce
9	led within 72 hours ygiene. "neturel", 'er then "neturel", ft, the Medical Exi Completed by	15. 0	ecedent's E	ducation		16a. D	ecedent's	Usuel Occu	petion			16b. K	ind of Bu	siness/Inc	lustry
H	uin 7	(Specify onl		ade completed)	4.400.5.1	- "i	Give kind d ife. DO NO	of work done OT use retire	during mos d)	st of work	ang				
Ξ	be filed within 7 ital Hygiene. d other than "n avent, the Med	Elementery/Secondary	(0-12)	College (1-40r 5+)		Home	emaker						Ot.m	home
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a	ntal H ad out								N/		C1			•	
5	d Men d Men d Merke nertic								_		Gladne	*			
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	end eelit n 27	Valerie Gue		Daughte					t Ave	nue					nd 21817
5	of H	20a. Method of Dispositio 1 ☑ Burial 2 ☐ Cree		Bomovol from		Place of D cemetery,	isposition cremetory	(Name of or other ple	ice)		Date	20c. L	ocation -	City or To	wn, State
Baltimore,	permit. Pegas 1 end 2 Depertment of Heelth a Important: if Itam 27 is any Injury or other tra anca.	4 Donation 5 0	Other (Special	fy)	V.	F.W.	Memor	rial C	emete	ry	4/2/07	Cr	isfi	eld,	Maryland
=======================================	permit. Pe Depertmer Important: any Injury ance.	21. Signature of Funeral	Service Lice	psee /	3	,		ne and Addre							
ä	perm Depe Impo any I	Maryk	othe	well	mill		Brac	dshaw	& Son	s Fu	neral E	Iome			
_		Mary Bet	h Brac	lshaw-Pr	uitt_		_306	.W. Ma	in St	-	Crisfie	ld,	MD :	21817	
		23a. Part1. En er the dise shock, or heart failu	ese, or com re. List only	plications that of one cause on e	aused the dea ech line.	ath. Do no	enter the	mode of dyi	ng, such es	cardiac	or respiratory a	rrest,			Approximate Interval Between
	Physician			1		**		,							Onset and Death
7	/Medical	Immediate Cause (Final disease or condition		. H.	rite	Mu	1000	madis	e 1.	NFI	minos	\sim	1	MI	Nutes
	Examiner	resulting in death)		а	Due to	(or as a co	nsequence	e of):							-
	ةِ حَالَ														
	certificate be axecuted nding physician and use as the burial-transit n/Medical Examiner	Sequentially list condition		b	Due to	(or es e co	nseauence	e of):							
ć	EX Parage	if eny, leading to immedia	ite											1	
68760,	e busicia	Sequentially list condition if eny, leading to immedia cause. Enter Underlying Ceuse (Disease or injury that initiated events	<	C	Due to	(or as e cor		αf):						-	
89	ficat phy is th	resulting in death) Last			Due to	(OI as e coi	isequence	ol).						1	
X	ding se a			d											
B	atter affor u													l	
o.	The law requires that the death ata been signed by the atte page 2 should be deteched for the Completed by Physicia	Part II. Other significant of	conditions o	ontributing to de	eath but not re	sulting in th	ne underfyi	ing cause gi	ven in Part	l.	23b. Did	tobacco	use cor	tribute to	the cause of death?
P.0	d by										1 🗆	Yes 3	No	3 Prob	ably 4 Unknown
	igne bed by														
Records,	en s buld										24a. Was	an auto	psy	ava	re autopsy findings illable prior to
ပ္ထ	s be 2 sh														npletion of cause leath?
æ	The law requir sata has been s paga 2 should										2 3000	Ven 9	260	10	Yes 20 No
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of Vital	Physician: The I this certificate he ral director, paga	25. Was case referred to examiner?	medicai	Hospital:				Ott	oor.		h (Check only o				
ō	5 5 7	1 Yes 2 No		101		ER/Outpa		J DOA	4U NI		me 5 Resi)
	leath. tor: After thi the funaral cation: 1	27. Menner of Death 1 ☑ Naturel 5 □	Pending		th, Dey Year)	28b. Tim Inju	ry	28c. Inju	rk?		28d. Describe	now inju	y occurr	ea	
Division	Attending in death. actor: After by the funa	2 Accident	Could not b				М	1	Yes 2□	No					
Ž	r Att	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	286. Place	of Injury - At I	home, farm	, street, fa	ctory, office			28f. Location (: City or Tox			er or Rura	Route Number,
0	tal or Attanding P is after death. al Director: After t led in by the funars Certification:				1-2										
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funar Medical Certification			ysician: To the											
	thin 24 hours thin 24 hours the Funer impletely fill	(Check only 2 M	edical Exam	niner: On the ba end man	asis of examin ner stated.	ation end/o	ir investiga	ation, in my o	opinion, dea	un occurr	ed et the time,	date and	ı piace, a	and due to	tne cause(s)
	M. M. M. M. M. M. M. M. M. M. M. M. M. M	29b. Signature and title of	certifier	Carl.	7			29c. Licens	e number			29d. Da	te signe	(Month, L	Dey, Year)
		1 hud	roel	Cl	Jus 1	no		7)-	390	17		~	/-	19/	
		20 Name and address of	nomort	nomelated ex	and door to	- 02-1 /-	no Drine	1	10	1 >			1 -	-11	
		30. Name end address of	CINS	mo	20	0/ 6	1100	ell	igho	wy	- CRI	SE	rele	e, M.	04817
	State Registrar	31. Date filed (Month, Day	PR02	2007 32. R	egisfar's Sign	nature	So	ريهان							

		Please	Type or Print						Legible.	
		For 1 _ State	State of Mary		epartment of		Mental Hy	giene	0007	11000
		Registrar 1. Decedent's Name (First, Middle, L	204		Certificate of	Death	2. Date of De	Reg. No.	2007	3. Time of Death
Physi	cian	Dolores	•	ller			Month April	Day 1	2007	5:45 A M
/Med Exam		4a. Facility Name (If not institution, g		1161	4b. City, Town,	or Location of Deat	1 1	4c. (County of Death	
LAGII	illei	Kline Hospice H	louse		Mt.	Airy			Freder	ick
Funera	al	Social Security Number 6.		n yrs. last birt	Months Days		8. Date of Bir (Month, Da	th ay, Year)	9. Birth Con	place (State or Foreign untry)
Directo	r	385-40-1575 Usual Residence of Decedent		66	rs. Monato Baye		Jan. 30	, 19	41 Mic	higan
/land ow		10a. State 10b. County	10	c. City, Town	or Location				Total Control of the	10d. Inside City Limits
Man a-f sh	cto	Maryland Frede	rick		Frederic	ζ				1 □Yes 🎢 □No
ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Co	untry?
If a refer to the many and filed within the Maryland filed within 72 hours after death with the Maryland Hygiene. The than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	5598 Teakwood Co	urt 12. Was Decedent Eve	r in II C		21703	Proping Voc or No		ted Sta	
ter de item	Fune	11. Marital Status 1 □ Never Married 2 ☑ Married	Armed Forces?	r in U.S.	13. Was Decedent of If Yes, specify Cu		to Rican, etc.)	, '	Black, White	
urs af al", or Exam	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 😾 No	Specify:			Specify: W	hite
72 ho	Completed	15. Decedent's (Specify only highest g	Education grade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	ipation during most of wo	rking	16b. Kir	nd of Business/I	ndustry
vithin ne. han "	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	l l	Tife. DO NOT use retir Homemaker	ed)			Own Ho	me
filed v Hygie ther t		17. Father's Name (First, Middle, La		1	itomematic 2	18. Mother's Nar	me (First, Middle	, Maiden 3		
ld be ental ked o	To Be		,			Viro	inia Rid	l1ev		
s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Stree				Town, State, Z	ip Code)
and 2		Jerome H. Mille			98 Teakwocd	l Court,				
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	□Removal from State	cemeter	Disposition (Name of y, crematory or other pl		Date		cation - City or	•
tment tant:		4 □ Donation 5 □ Other (Spec	cify)	Stauff	er Cremator				erick, neral H	Maryland
permi Depar Impo	200	21. Signature of Funeral Service Lic	ensee			ssumtown				
TE A		23 art1. Enter the disease, or co	mplicans that caused the	e death. Do n						Approximate
Physiciar		shock, or heart Mure. List on Immediate Cause (Final	ly one cause on each line.	+:0	hneart	Can	cor		1	Interval Between Onset and Death
/Medica		disease or condition resulting in death)	Due to (or as a co		77	Carre				157
Examine		Sequentially list conditions.	b							
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence o	if):					
xecut and	xan	that initiated events resulting in death) Last	c Due to (or as a co	onsequence o	rf):					
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		1	d							
tifficat og phy as th	Physician/Medical	15.55441.5								
leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1 Live birth 2	Fetal death	3 □Ectopic pregnan	су		2	3d. Date of deli Month	very Day Year
ne dea the at	/sici	1 ☐ Yes 2 DNo 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of death	5 ☐ Other (specify)				World	buy rou
res that the de signed by the a		Part II. Other significant conditions	contributing to death but no	ot resulting in	the underlying cause g	iven in Part I.	23e. Did 1	tobacco us	se contribute to	the cause of death?
quires n sign	d by			~			10	Yes 2	Xvo 3□Pro	obably 4 □Unknown
aw require s been sign	Completed						24a. Was		24b. Were au	topsy findings available
The lav	mo						auto perfo 1∏ Yes	psy ormed? 2 No	death?	ompletion of cause of
	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o			Has Aires
Physician: r this certificaral director, p	입	1 ☐ Yes 2 No	Hospital: 1 Inpatient		patient 3 DOA		Home 5 ☐ Resi		Other (Spec	House
ing ing	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. T	ijury Wo	ury at ork? ∃Yes 2⊟No	28d. Describe	how injury	occurred .	
Attend death ctor: y the	ficat	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of injury		m, street, factory, office					ral Route Number,
affer affer d in b	Certification:	4 Homicide	building, etc. (S	Specify)			City or To	wn, State)		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune			Physician: To the best of maminer: On the basis of ex							
thin 24	Medical	one) 29b. Signature and title of certifier	and manner stated		9c. Licer	ise number		29d. Date	ş signed (Month	n, Day, Year)
5.¥ ± 8		- Houny	Espartates	and	7	54818	4	4/	210	7
10		30. Name and address of person wh	o completed cause of death	ı (Item 23a) (Type, Print)	710	1	/	1 = 1	ANK MD
10		Elhamy E	3 Kander	, MI	> 501	w Tt	n 5t	reet	1 truck	21701
S Regis	tate strar	31. Date filed (Month, Day, Year) APR 0 2	2007 32. Phistrar's	Signature	spartes					

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CR/10/	
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			1 - State Registrar/Amend#1.PerPhys.PGC3-29-07cm	Certificate of Death	Reg. N	10.2007 11909
т	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	/Media			McCormick	March 24	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		36	Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. 1	ast birthday) If Under 1 Year If Under 24 Hrs.		Prince George's
2	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I I I M 2 1	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Aug. 14,1	
	/land ow			r, Town or Location		10d. Inside City Limits
	Man -f sh fled	tor	MD Prince George's	Suitland		1 DAYes 2 □ No
	n the	Funeral Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	h with	a D	5502 Vernon Way	20746		USA
	deat	ner	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?		ecify Yes or No-	14. Race - American Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	nican, etc.)	Black, White, etc. Specify: White
5-	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)	16b.	Kind of Business/Industry
12	within iene. than "	ш	Elementary/Secondary (0-12) College (1-4or 5+)	_ '		m 1 13
	filed v Hygie ther t		12 17. Father's Name (First, Middle, Last)	Personnel 18 Mathada Nama	(First Middle Maid	Retail
auc	ould be f Mental H arked ot atic eve	Be			e (First, Middle, Maide	an Surname)
Ë	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	ဥ	Wakeen Swor 19a. Informant's Name/Relationship (Type. Print)	Edna No		
Maryland	d2sh thanc 7isπ traun		Diana Millios /daughter	19b. Mailing Address (Street and Number or Rura		. ,
	es 1 and 2 of Health a litem 27 is r other tra				Bowie, MD.	Location - City or Town, State
Baltimore,	ages ent of t: If its y or o	3	1 E3 Buriar 2 Defendation 3 DRemoval from State			,
≢	permit. Pages Department of Important: If i any injury or once.	ī	21. Signature of Funeral Service Licensee	20 Name and Address of Facility		rentwood, MD.
Ba	permit. Departr Importa any inju	1	Church Voundly	6512 NW Crain High	all Funera	
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.			20715 Approximate Interval Between
	Physician	5 19	Immediate Cause (Final			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as on sequence of the control of the con	ence of):		
	Examiner	Ш	1.	1 Kemin		
	To The Park	ner	Sequentially list conditions, if any, leading to immediate Cause Function limited and	ence of):		
	cuted	Examiner	if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events			
ó	e exe ian aı ırial-t		resulting in death) Last Due to (or as a consequ	ence of):		
68760,	ate b hysic the bi	Medical	d			
~	ertific ling p	Med	IF FEMALE:			
. Bo	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
P.0	that the set by detac		Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
or Vital Records,	sign d be	d by			1 ☐ Yes	2 No 3 Probably 4 Unknown
20.	w requir been si should	ete				
Re	he lav e has ge 2 s	Completed	4/1-1		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
g			25. Was case referred to medical		1□ Yes 2☑N	No 1 ☐ Yes 2 ☐ No
Ξ	Physician: rthis certific ral director,	Be	examiner?	26. Place of Death 27. Place of Death 28. Other: 4 ☐ Nursing Hor		
0	y Physer this eral di	٦. ا	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at 2	me 5 ☐ Residence 28d. Describe how inj	6 ☐Other (Specify)
<u>o</u>	nding F th.	tio	1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No		, · · · · · · ·
Division	Attend r death ector:	lfica	3 Suicide 6 Could not be 28e. Place of injury - At hor	me, farm, street, factory, office	28f. Location (Street a	and Number or Rural Route Number,
	s after s afte	Certification:	4 Homicide determined building, etc. (Specify,		City or Town, Sta	ite)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner/stated.	vledge, death occurred at the time, date and place, a on and/or investigation, in my opinion, death occurr	and due to the cause(ed at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	29c. License number	29d. D	Pate signed (Month, Day, Year)
				→ D0039	691 0	2/25/07
a li	2/10/	Ī	30. Name and address of person who completed cause of death (Item			1
4	['/				mple Hills	, MD 20748
	Sta Registra		31. Date filed (Month, Day, Year) MAR 2 9 2007 32. Registrar's Signate O. M.	and .		

State of Maryland / Department of Health and Mental Hygiene) 0 0 7

						Certificate of	Death		Reg. No.	JI	11310
	Physicia /Medic		1. Decedent's Name (First, Middle Jennifer	le, Last) Mar	ie	Miller		2. Dete of Dea Month March 24	ath	Year	3. Time of Death 1:50 P
-	Examin		4a Fecility Name (If not institution		ar)		4b. City, Town, or L Clinton	ocation of Deeth	4c. County Prince		e's
			7503 Carrico Avenu 5. Social Security Number		Age (In yrs. last b	inthday) If Under 1 Year		8 Date of Birt			ace (State or Foreign
	Funeral Director		577-68-9561 Usuel Residence of Decedent	1□ M 2∰F	54	Yrs. Months Days		January	y, Year) 31, 1953	Coun Was	hington, DC
	puel Man		10a. Stete 10b. County		10c. City, To	wn or Location				11	0d. Inside City Limits
	Mary Fed sh	ţ	Maryland Prince	George's		Clinton					1 ☐ Yes 2X No
	with the a or 28s	Funeral Director	10e. Street end Number 7503 Carrico Aver	nue	1	10f. Zip Code 20735			10g. Citizen of V USA	Vhet Coun	try?
	Jeeth me 23	era	11. Marital Status	12. Was Decede	nt Ever in U,S.	13. Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No-	14. Rac	e - Americ	
020	permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mentel Hygiene. Important: If itam 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at page.		1 ☐ Never Married 2/OX Man 3 ☐ Widowed 4 ☐ Divorced	If Yes Give		If Yes, specify Cub		Rican, etc.)	Specify	k, White, Wh	otc. uite
2-0	72 ho	eded		t's Education st grade completed)	16	a. Decedent's Usual Occur (Give kind of work done	pation during most of work	kina	16b. Kind of Bu	siness/Inc	lustry
12	han.	ğ	Elementary/Secondary (0-12)	College (1-4c	or 5+)	(Give kind of work done life. DO NOT use retire	nd)			In Ho	vmo.
5	iled v dygie her ti nt, th	S	9th 17. Fether's Neme (First, Middle,	(act)	}	Homemaker	18. Mother's Nam	e (First Middle	Maiden Surnam		ile .
an	d be f	To Be Completed by	Philip Redmor						rnes	-/	
Baltimore, Maryland 21215-0020	d 2 shoul thend Me 7 is mark traumati	۲	19a. Informant's Name/Relations Leonard Miller Jr.	ship (Type, Print)	19	b. Mailing Address (Street 7503 Carrico Av					Code)
<u>6</u>	Health Health am 27 other tr		20a. Method of Disposition	/ Hassana	20b. Place	of Disposition (Name of		Date	20c. Location -	City or To	wn, State
Ē	Pages nent of I int: If its iry or o		1 ☐ Buriel 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (S			ery, cremetory or other pla s Crematory	03	3/28/2007	Edgewate	er, Man	ryland
Balti	permit. Page Department Important: If any Injury or price.		21. Signature Funeral Service			22. Name and Addre	GE		alas Funer		
		-	AND .	also of	and the death. De	6160 Oxon H				20745	Approximate
	Physician /Medical Examiner	ler	2 1. P. 11. Enter the disease of nock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	e	METAS	TATIC LUNG C.					Interval Between Onset and Death
	cuted nd ransit	amir	Sequentially list conditions.	b	Due to (or es a	consequence of):				1	
Ď,	e exe ian ar unel-t	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury								
68760,	ntificete be executed ng physician and es the bunel-transit	edical Examiner	that initiated events resulting in death) Last	С.	Due to (or es e	consequence of):					
Box	anding use 6	∑ !	•	d						-	
	deeth	sicia	Part il. Other eignificant condition	ons contributing to death	but not resulting	in the underlying cause giv	ven in Part I.	23b. Did t	obacco use cor	ntribute to	the cause of death?
л. О.	that the ed by th detech	/ Physician/						101	Yes 2□ No	3 🕏 Prot	oably 4 Unknown
Division of Vital Records,	The law requires that the deeth certificete be executed at the been signed by the ettending physician and page 2 should be deteched for use es the buriel-transit	Completed by						24a. Wes	en autopsy rmed?	ava	ere autopsy findings allable prior to appletion of cause death?
ž	The law ate hes page 2	E O						101	ras 21XNo	10	Yes 2 No
<u> </u>	i cian : The certificete rector, pag	Be	25. Was case referred to medica examiner?	ı			26. Place of Dear	th (Check only o	ne)		
<u> </u>	Physic this ce ral dire	ူ	1 ☐ Yes 2 📉 No	Hospitel: 1 Inpa		dipatient 3L DOA			lence 6 DOth		<i>(</i>)
ב	ing P	ö	27. Manner of Death 1 △ Natural 5 ☐ Pendin		ojury Day Year) 28b.	Time of 28c. Injury Wo 1 □	ryat rk?]Yes 2 □ No	28d. Describe h	now injury occurr	ed	
NISIC	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	edical Certification:	2 Accident investig 3 Suicide 6 Could a 4 Homicide	not be 28e. Place of I	njury - At home, t etc. <i>(Specify)</i>	arm, street, factory, office	7165 Z NO	28f. Location (S City or Tow	Street and Numb m, State)	er or Rura	l Route Number,
2	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	a Cer	29a. Certifier 1XXcertifyin	g Physician: To the bes	st of my knowledg	e, death occurred at the ti	me, date end place,	end due to the o	cause(s) and ma	nner es st	ated.
	in 24 i		(Check only 2 Medical one)	Examiner: On the basis end manner		nd/or investigation, in my o	opinion, death occur	red at the time, o	date and place, a	and due to	the cause(s)
	Vithi Withi	Ž	29b. Signature and title of certifie	a late	5)-Sec	29c. Licens	se number 28079		29d. Date signed 03/27	d (Month, i 1/2007	Day, Year)
>	(4)		30. Name end address of person Francine Higgs-Shi	who completed cause of pman MD 9200	deeth (Item 23e) Basil Co	(Type Print) urt Largo, Mary	land 2077	4			
	Stat Registra		31. Date filed (Month, Day, Year) MAR 2 9 200	32. Regis	strer's Signeture	edd					
*			4.7.1.	/,							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death , 2007 Year March 27, Physician Floyd B. Martin, Sr. 11:30P™ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rexford Place Prince George's Greenbelt If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F 89 Yrs 212-16-6643 Dec 18, 1917 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner wast by notified at 1

Yes 2 □ No Maryland Prince George's Lanham Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8903 Hickory Hill Avenue 20706 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No WWII If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Warehouse Foreman Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important; if item 27 is marked other any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George Martin Minnie Engel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeanette M. Lizer (Daughter) 3876 Ponder Drive, Edgewater MD 20137 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Geo. Washington Cem. 3/31/2007 Adelphi, MD 21. Signatural Juneral Since Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician Congestive Heart Failure 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a nonsequence of) Examiner certificate be executed use as the burial-transit Due to (or as a consequence of): s been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Osteoporosis Renal Insufficiency 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypothyroidism autopsy performed 2□ No 1 Yes 2 No 1 ☐ Yes After this certification, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Certification: To Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No Director; / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division of Vital Records, within 24 hours after d To the Funeral Director completely filled in here.

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

State Registrar

115 Center Way, Greenbelt, MD 20770 31. Date filed (Month, Day, Year) 32. Registrar's Signarare

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Granite, M.D.

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** , 00 i /Medical 4a. Facility Name (If not institution, give street and number, Hebrew 4b. City, Town, or Location of Death 4c. County of Death Examiner Home of Greater Washington Montgomery Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
| Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director 052-05-8619 99 Yrs. 19, 1907 New York Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location Item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumetic event, the Medical Examinar must be notified at 10d. Inside City Limits 1∏Yes 2□No Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iten any injury or other traumetic event, the Medical Examinar once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 🔀 No White 3 √ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Bookkeeper Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Sweedler Esther Zuckerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Jacob - Daughter 1719 Ivy Oak Square, Reston, Virginia 20a. Method of Disposition

1 🖰 Burial 2 Cremation 3 □Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gdns 3/25/2007 Olney, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Edward Sagel Funeral Direction,
1091 Rockville Pike, Rockville, Donald 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ₺No 1 Yes 2 PNo To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death Check onl. one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 🗀 Inpatient 2 ER/Outpatient 3 DOA inis funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. investigation 1 Tyes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person MONT ROSE-ROAD 31. Date filed (Month, Day, Year) Registrar

Division or Vital Records, P.O. Box 68760,

Hospital or Attending thin 24 hours after oeau...

o the Funeral Director: Af To the 0

Registrar DHMH 17 Rev 1/2001

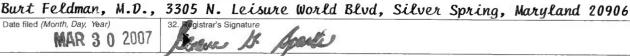
10

31. Date filed (Month, Day, Year) MAR 3 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier



29c. License number

D23958

29d. Date signed (Month, Day, Year)

March 29, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stete Registrar AMEND#27perDME,3/30/07,BMW,MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MORYIS 22 08300 M man >ara 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Srlver 9 Cross HOI VIng man 20mer 1409P If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year Months Hours Mir 1 ☐ M 2 🖾 F Yrs Director 214-12-3521 89 September 25,1917 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f ehov the Medical Exeminer must be notified at 1 Tyes 2 x No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10000 Brunswick Avenue 20910 U.S.A. Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 X No 1 Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No ģ Specify: 3 XWidowed 4 □ Divorced White "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Typist U.S. Government 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be lift Depertment of Health and Mental Hy Important: If Item 27 is marked oth eny liqury or other traumatic event 9DR. 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Michael Sachs Ida Edladoldich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11000 Broadmore Place, Silver Spring, Maryland 20904 Robert Morris - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington National Cemetery 4/6/2007 Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of) OME Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ettending physicien end resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav 4☐Pregnant at time of death signed by the el 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificate 1□ Yes 20 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral directors. Certification: To this 28a. Da e ol Injury (Month, Day Year) er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Accident 5 Pending Patient fell from bed on IMC unit. 0645AM investigation 1 ☐ Yes 2 🗷 No 3120107 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide HOLY CROSS HOSPITAL 1500 FOREST GLEN RD SS MD 2090 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

Day Year)

2007

			For State Registrar		f Marylan	d / Dep		t of H	lealth a	and M	lental Hy		n 7		5
	- # L	13	Decedent's Name (First, Middle,	Last)							2. Date of De		.,	3. Time of	Death
15	Physici		Winston Morri	s Moore	Jr.						Month March	26,	Year 2007	0520	M
	/Medic Examin	-	4a. Facility Name (If not institution,	give street and nur	nber)		4b. City,	Town, or	Location	of Death		4c. Cour	nty of Death	-	
			Holy Cross Ho	spital					pring				gomer		
	Funeral			6. Sex 1	7. Age (In yrs.		If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da			olace (State or ntry)	
ď.	Director		257-26-2468 Usual Residence of Decedent		84	115.					Sep. 28	3, 1922	Lane	tt, AL	
	and and		10a. State 10b. County		10c. Cit	ty, Town or L	ocation						1	0d. Inside Cit	y Limits
	Maryl f sho	ō	MD Montgo	omerv	Si	lver S	Snrine	Y						1 X Yes	2 □ No
	the 28a-	Director	10e. Street and Number			-1.401	10f. Zip					10g. Citizen o	of What Cour	ntry?	
	3a ol	al D	6 Turnmore Ct.					2090	06			U.S.	A		
	death ms 2	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Dece	dent of H	ispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	o- 14. R	ace - Americ lack, White,		
ထွ	after or ite mine		1 ☐ Never Married 2X Marrie		2 X No		1 ☐ Yes						cify: Blac		
8	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ates:										
<u>7</u>	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, <u>the Medical Examiner must be notifled at</u>	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usua kind of wo DO NOT us	al Occup rk done (ation during mos	t of worki	ng	16b. Kind of	Business/in	dustry	
7	withir ene. than	d mo	Elementary/Secondary (0-12)	College (1	-4or 5+)		rical					Priva	te		
9	filed Hygid Ither		17. Father's Name (First, Middle, L.			ETEC	LILCa.	L 1510	_		(First, Middle	, Maiden Surn			
Maryland 21215-0036	buld be f Mental I arked of atic eve	To Be	Winston Moore	Sr.				,	E1	la C	arlton				
JE J	S D E E	-	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Maili	ng Address	(Street	and Numb	er or Rura	al Route Numb	per, City or Tow	ın, State, Zip	Code)	
	alth a alth a 27 is		Effie Moore / N	Wife		6 Tu	nmore	e Ct.	Sil	ver	Spring,	MD 20	906		
Je,	of He	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, cemetery, crematory or other place)										own, State			
Ĕ	Page nent ant: It		4 Donation 5 Dother (Sp			rk Law	n Cem	•	A	pri1	2, 20	07 Rock	ville	, MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai		21. Signature of Funeral Service L	icensee								Funeral			
ш	<u>205</u>		Unilee"	Houses								ashingt	on, D	_	
П		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Betw Onset and D	veen	
	Physician		Immediate Cause (Final disease or condition resulting in death)		liopu1m		Arres	t							
	/Medical Examiner		rosaning in ossain,		or as a conseq		otion								
i,		je.	Sequentially list conditions,	b	cardial or as a conseq		CLION								
	nted Insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Seps											
Ć,	e be executed /sician and e burial-transit	Examiner	that initiated events resulting in death) Last	C	or as a conseq	uence of):									
760,	te be ysicia	cal	.19	d. Acut	e Renai	l Fail	ure				-				
9	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medi	IF FEMALE:												
õ	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	aldeath 3[⊒Ectopic p		,				Date of delive Month		/ear
0	e dea the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregr 9□Unkno	ant at time of one	death 5	Other (sp	ecify)							
Vital Records, P.O. Box	hat the	Phy	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	ınderlying c	ause give	en in Part I	 I.	23e. Did	tobacco use co	ontribute to t	he cause of de	eath?
ds,	signe d be	l by	Atrial Fibri				, ,				1 🗆	Yes 2 No	3 □ Prot	oably 4 X U	Jnknown
Ö	v requ	etec	Dehydration								24a. Was	s an 24	h. Were auto	onsy findings a	available
Be	he lav e has ge 2	dm									auto perf	ormed?	death?	ppsy findings a mpletion of ca	use of
ā	in: Tificate		25. Was case referred to medical						26 Place	e of Death	1 Yes 1 (Check only	2 🖾 No	1 ∐ Yes	2□ No	
>	ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2X No	Hospital:	npatient 2 🔀	ER/Outpatie	nt 3 🗆 DC	OA Oth	er.			idence 6 🗆 0	Other (Special	fy)	
Division or	g Phy ier thi		27. Manner of Death	28a. Date	of Injury	28b. Time of	of 2	28c. Injur Worl				how injury occ			
Ö	ath. or: Aff	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	ation	,,,	,,	M		Yes 2□	No					
<u>S</u>	or Atterderinecterinecter	27. Manner of Death 1 X Natural 1 Q Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28a. Date of Injury M 1 Vork? 1 Vork? 1 Ves 2 It 28b. Place of injury - At home, farm, street, factory, office 28b. Place of injury - At home, farm, street, factory, office									(Street and Nui wn, State)	mber or Rura	al Route Numi	ber,	
	urs aff							-444*-							
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	To the Hospital or Atter within 24 hours after deat within 24 hours after deat To the Funeral Director completely filled in by the	Medical	29b. Signature and title of certifier	and man	nei stateu.		290	c. License	e number			29d. Date sig	ned (Month,	Day, Year)	
1			· Sanda	110	-000	110	<u>ا</u> ر	, D006.	5060			March	26 20	007	
	PD		30. Name and address of person W	ho completed caus	e of death (Iter	n 23a) (Type.		0000.	2007			March	20, 20	JU /	
			Sirak H. Lemma	-	500 For			nad•	Silv	er Si	orina.	MD 20	910		
	Sta	te	31. Date filed (Month, Day, Year)	2007 32.	gistrar's Signa	ature	Const	6							
	Registr	ar	MAR 3 0	2001	gistrar's Signa	15 /9									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			1- For State Registrar		•	ate of De				Reg. No.						
M	Physici edical Exam		Decedent's Name (First, Middle,	-					2. Date of De Month	eath Apr	il 5, 2007	3. Time of Death 4430 hrs 1442				
100	eulcai Exam	mei	Wesley Alan Mi 4a. Facility Name (if not institution,			4b. Ci	itv. Town. or	Location of I	April 4, 2		County of Death	143011132112				
	<i>)</i>		Holy Cross Hospital	give en est an a vania est,			lver Sprin				ontgomery					
- C	Funeral		Social Security Number 6	. Sex 7. Age (In yr	s. last birt		Under 1 Yea		24Hrs. 8. Date of E	Birth(MM/I	DD/YYYY) 9. Birth Foreign	,				
-	Director		218-54-9321 Usual Residence of Decedent	X M 2 F	49	Yrs.	Officis Day	's Hours	Aug.	28,		ntry) NJ				
	v any		10a. State 10b. County	10c. C	City, Town	or Location		-				0d. Inside City Limits				
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	e Mary or 28a ied at	Director	10e. Street and Number				. Zip Code				zen of What Count					
	vith th s 23a e notif	ם	24 Walker Avenue	12. Was Decedent Ever in	n U. S .		20877 cedent of His	spanic Origin	? (Specify Yes or I		ted State 14. Race - America					
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)36 hin 72 e. than '	Completed	12	College (1-4 of 5+)	P.	ainter				Cor	nstructio	n				
	5-0C led wit tygien other the M	ပ္ပြ	17. Father's Name (First, Middle, La	ast)				18.Mother's	Name (First, Middle	ame (First, Middle, Maiden Surname)						
	121 d be fi lental] arked	Be G	Wyndham D. Mile 19a. Informant's Name/Relationship	S Sint	40	- Maritim - Andal	(0)		dine Goleman or Rural Route Number, City or Town, State, Zip Code)							
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department Beath and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ပ	Geraldine Miles			_				sburg, MD 20877						
	e, N l and Health item		20a. Method of Disposition	20	b. Place o	of Disposition ((Name of ce		Date	20c. Location - City or Town, State						
	MOF Pages ent of int: If	,	1 X Burial 2 Cremation 4 Donation 5 Other Spec		metery 4/10/2007 Germantown, Maryland											
	Baltil permit Departm Importa	d	21. Signature of Funeral Service Li													
		17	Jeffrey S. Titcomb, 23a. Part I. Enter the disease, or co		ath Dono	Gaitf	iersbu	such as care	1 20877	rrest sho	ock, or heart	Approximate Interval				
	Physician /Medical		failure. List only one cause or	n each line.								Between Onset and Death				
	Examiner		Immediate Cause (Final disease or condition resulting in death) Meningitis complicating hypertensive cardiovascular disease Due to (or as a consequence of):													
		<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	ce of):											
		Examine	cause. Enter Underlying Cause (Disease or injury that initiated	C												
	outed nd ransit	Exa	events resulting in death) Last	Due to (or as a consequence d.	ce of):											
	Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	X UNPENDED	X AMENDED, 23a, 27,		., 21, pe	erFH, G	368 <u>, 6/1</u>	5/07 TT	Loc						
	876 tificate ing phy as the l	W/W	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p		2 Fetal de	eath 3	Ectopic p	regnancy	230	d. Date of delivery Month Da	y Year				
	Box 687 ne death certific the attending p	Physician/	1 Yes 2 No 9 Unknown	own 9 Unknown	f death	5 Other ((Specify)									
	J. B. the de by the	Phy	Part II. Other significant conditio		ot resultin	g in the under	lying cause	given in Part	I. 23e. Did	tobacco	use contribute to th	e cause of death?				
	, P.C res that signed be deta	d by							_ 1 _ \	es 2	No 3 Proba	bly 4 🗸 Unknown				
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BRILY	tal I cian: certifi rector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Innationt 2			26.Plac	I Other -	heck only one) Nursing Home 5	Reside	ence 6 Other:					
	of Vi Physi rer this	<u>د</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a Date of Injury (Month, Day, Year)		Time of Injury		ury at Work?	28d. Describ							
Cld	on c ending ath. or: Af	tion	1 X Natural 5 Pendir	ng			1	Yes 2 N	0							
#21-	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ras after death. an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	ifica	1 Natural 5 Pending Investigation 2 Accident Accident Investigation 2 Accident Investigation 2 Specify 2 Accident Investigation 2 Accident Investigation 2 Accident 2 Accident 2 Accident 2 Accident 2 Accident 3 Suicide 4 Homicide Accident									al Route Number, City				
#	Division ospital or Attend hours after death.	Ser	4 Homicide determ	1000000												
	Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical		sician: To the best of my know iner: On the basis of examination	vledge, de on and/or i	ath occurred a investigation, i	at the time, o in my opinio	late and place n, death occu	e, and due to the ca rred at the time, da	iuse(s) an te and pla	id manner as stated ace, and due to the	a. cause(s)				
	To Too	Mec	29b. Signature and title of certifier	and manner stated.			29c. Licen	se number		29d.	Date signed (Moni	h, Day, Year)				
			The whow M.	16 , a 50, 1	w		O.C	.M.E.		Apr	il 6, 2007					
-	3		30. Name and address of person w			iner 111	1 Penn S	treet Ralti	more, MD 212	01						
		late.	Theodore M. King, Jr.,	MD. Assistant Medica		-			more, wid 212	-						
	Senis	tate	AFR 10	LUU/ 190000	M	Some	A .									

		For State Registrar	State of Marylar		artment rtificate			Mer		iene og. No.		11917
Physici	an	Decedent's Name (First, Middle, Last) ROBERTO	GUIDO MO	NDRAG01	vī.				Date of Death Month ARCH	_) 0°7°	3. Time of Death 6:00 P M
/Medic Examin		4a. Facility Name (If not institution, give st. 4002 OLIVER STREET		NDRAGOI	4b. City, T		Location of Dea	ith		4c. County		GEORGE'S
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1		If Under 24 Hr. Hours Mir	s. 8. 0	Date of Birth (Month, Day, CT. 23	Year)		place (State or Foreign
e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County MD PRINCE GEO		ty, Town or Lo								10d. Inside City Limits
n with th	ai Dire	10e. Street and Number 4002 OLIVER STRE	ET		10f. Zip (ode 2078	2		10	og. Citizen of V MEXICO		ntry?
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. I not Health and Mental Hygiene. I no Health and Mental Hygiene is not the real than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notilised at	d by Funeral Director	11. Marital Status 12 Married 12 Married 3 Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decede f Yes, specif 1 X Yes 2	y Cubar	panic Origin? (, Mexican, Pue Specify:	Specify into Rica	Yes or No- an, etc.)	14. Rac	e - Americk, White,	can Indian, etc.
21215-0036 of within 72 hours af giene. or than "natural", or the Medical Exert.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 6th	ation completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use ORER	done di	uring most of wi	orking		16b. Kind of Bu		dustry
Maryland 2121 d 2 should be filed within int and Mental Hygiene. The marked other than traumatic event, the Me	To Be	17. Father's Name (First, Middle, Last) COSME GUIDO					18. Mother's Na	ne <i>(Fi</i>	irst, Middle, M JESUS		,	I
, Maryla and 2 should ealth and Men n 27 is markener traumatic.	19a. Informant's Name/Relationship (Type, Print) MARIA GUIDO/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numbe											Code)
Baltimore, Moernit. Pages 1 and 2 Opportment of Health mportant: if them 27 in y injury or other tra		20a. Method of Disposition 1 \overline{\Omega} Burial 2 \subseteq Cremation 3 \subseteq Removal from State 4 \subseteq Donation 5 \subseteq Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY 4/2/2007										own, State RYLAND LNG,
Baltimo		21. Signature of Funeral Service Licensee	hall		Name and		s of Facility OVER ROA			CINS FU ER,MARY		L HOME 20785
Crate be executed /Medical Examiner bhysician and sthe buriat-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List thy one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death
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cords, P.O w requires that the been signed by th should be detache	þ	Part II. Other significant conditions conti	buting to death but not res	sulting in the u	nderlying ca	ise give	n in Part I.				nbute to t	he cause of death?
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Division of Vita Vita No. 10 Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	lon; To Be	27. Manner of Death 1 X Natural 5 □ Pending	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28	c. Injury Work	at ?	Home	5X Reside	nce 6 □Oth		(y)
Division al or Attending s after death. Il Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory,		es 2 □ No	28f.	Location (Sti City or Town		er or Rur	al Route Number,
ne Hospit 7 24 hour ne Funera	edicai (29a. Certifier (Check only one) 1 X Certifying Physical Cartifying	r: On the best of my kn r: On the besis of examination	owledge, deatl ation and/or in	n occurred as vestigation, i	the time	e, date and place inion, death occ	ce, and curred a	due to the ca	use(s) and ma ate and place,	anner as s and due t	stated. o the cause(s)
within Total Comp	Me	29b. Signature and title of certifier Cartain 30. Name and address of person who com	inplement and the state of death (Ite	m 23a) (Type.	4	License	5796		29	3 (2	d (Month,	Day, Year)
_(3)	ate	CLAYTON W. STRAUG 31. Date filed (Month, Day, Year) APR 0 2 2007	//	QUEENS		OAD.	SUITE	103	RIVERI	DALE,MA	RYLA	ND 20737

			1 - For State Registrar		Marylar		artmen rtificat			and M	lental Hy	giene Reg. No	ZIIII	11918		
	Physici	an	Decedent's Name (First, Middle, Las	t)							Date of De Month	ath Da	y Year	3. Time of Death		
	/Medic		JESSE MCIVER								March 2	-		9:30 P.M		
	Examin	er	4a. Facility Name (If not institution, give						Location o	f Death			. County of Death			
			St. Thomas More N 5. Social Security Number 6. Se		dome . Age (In yrs.	last hirthday)	Hya1	ttsv:	IIILE	24 Hrs.	9 Date of Bin		rince Ge			
	Funeral Director			M 2□ F	81	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 1/03/1	y, Year)	Col	pplace (State or Foreign intry) ford, NC		
			Usual Residence of Decedent				l				1/05/1	1920	Dall	TOTA, NO		
	rylan thow	_	10a. State 10b. County			ty, Town or Lo								10d. Inside City Limits		
	Ba-f	cto	Maryland Prince G	eorges	нуа	attsvil	LTe							1 X Yes 2 No		
	ath with the Marylan 23e or 28e-f show		10e. Street and Number				10f. Zip						izen of What Cou	•		
	s 23	eral	6020 Sargent Road,	#2108	lant Evar in 11	S 123	Man Dane		782	-:-2 (0	-4		ted Stat			
	fter d	Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Ford	es?	.5.	f Yes, spec	ify Cubai	n, Mexican	, Puerto	cify Yes or No Rican, etc.))-	14. Race - Amer Black, White			
3	ours after de: el', or Items Extendiner o	ρχ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es: 1944-	-46	1□Yes 2	2 ∑ No	Specify:				Specify Blac	k		
5-0036	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	ucation		16a. Dece	dent's Usua	I Occupa	ition	of worki	na	16b. K	ind of Business/Ir	ndustry		
2	within ene. then "	npl	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. I	kind of wor DO NOT us	e retired,)	Or WORK	,g					
7	filed w Hygier other th	Co	12 17. Father's Name (First, Middle, Last)	4		Comme	ercial	LArt		da Nama	(Cinc. Minhalla	Private st, Middle, Maiden Sumame)				
and	od tal	Be c	James McIver									, Maiden	Sumame)			
5	should nd Men marke umatic	ဥ	19a. Informant's Name/Relationship (7	vpe. Print)		19b Mailir	na Address	(Street a			McLean	er City o	or Town, State, Zi	in Code)		
Σ	od 2 Ith a 27 is		Ruth McIver (wif										ville, M	· ·		
ore,	es 1 ar of Hea fitem		20a. Method of Disposition		20b. F	Place of Dispo cemetery, cren			144		ate		ocation - City or T			
Ε	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		iara				- 1	3/3	0/2007	Was	shington	, DC		
<u>a</u>	permit. Page Department Important: If any injury or once.		'4X Donation 5 □ Other (Specify) Howard Univ. Med School 3/30/2007 Wa 21. Signature Fineral Service Licenses P.A.													
D	207 2 2	4	Carry J. K	rimme	na								le, MD 2	0747		
Ī	Priysician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or teart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										st	Approximate Interval Between Onset and Death		
,00790	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or	r as a conseq	uence of):										
O. BOX 6	the death certifica y the attending ph ched for use as t	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Feta nt at time of d	Ideath 3□	Ectopic pre						23d. Date of deliv Month	ery Day Year		
ecords, P	The law requires that the ate has been signed by the page 2 should be detached.	Completed by Ph	Part II. Other significant conditions of	1)	th but not res	_	nderlying ca	iuse give	n in Part I.			obacco u Yes 2		the cause of death?		
รู	s beer	lete	Dements	-							24a. Was	an	24b. Were auto	opsy findings available		
ב	The la	E O	CVACTOR)					•		autop perfo	rmed?	death?	ompletion of cause of 2 No		
	len: rtifica stor, p	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		1 1 103	2010		
> 5	hysic nis ce I direc	ToE	1 Yes 2 No	lospital: 1 Inp		ER/Outpatien	t 3□ DO	A Othe	r: 4 🖪 Nur	sing Hon	ne 5 □ Resid	dence	6 □Other (Speci	fy)		
⊃ =	ng Pl		27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28	Bc. Injury Work	at ?	2	8d. Describe h	now injur	y occurred			
VISION	tendi death. tor: A the fu	cat	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 N							
2	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	4 Homicide determined	building	, etc. (Specify						City or Ton	vn, State)	al Route Number,		
	te Hosp 24 hores te Fune letely fi	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	sicien: To the b ner: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred a estigation.	it the time in my opi	e, date and inion, deat	l place, a h occurre	nd due to the o d at the time, o	cause(s) date and	and manner as s place, and due t	stated, o the cause(s)		
	To the within To the comp	Me	29b. Signature and title of certifier	1	-0	,	29c.	License	number			29d. Dai	e signed (Month,	Day, Year)		
			1 Jon Oll	de	eld		1	101	85	2	-	25	MANCH	12007		
-	(3)		30. Name and address of person who c	ORE M	of death (Item	123a) (Type, 1	Print)	sbut	y rd	My	4 ltvi	114	MANCH MANCH MA) Zo	741		
	Stat Registra	_	31. Date filed (Month, Day, Year) #AR 3 0 2007	32. Reg	jistrar's Signa	me de										

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** HELEN JOAN MARSH MAR₂₇ 2007 4:33 P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OCT.13,1926 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2/2 X 317-28-5800 80 Yrs. INDIANA Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23s or 28s-f show the Medical Example intest for notified at 1 ☐ Yes 2 ☐ No Funeral Director VIRGINIA FAIRFAX FALLS CHURCH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6659 AVIGNON BLVD 22043 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental LEONARD FRANCIS SPEARS CHLOE ELZORA WILLIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT T. MARSH - HUSBAND If Item 27 I 6659 AVIGNON BLVD FALLS CHURCH, VA 22043 other ! 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ă NATIONAL CREMATORY APRIL 2, 2007 FALLS CHURCH, VA 22. Name and Address of Facility DEMAINE FUNERAL HOME
520 S. WASHINGTON STREET ALEXANDRIA, VA 22314 21. Skynature of Eunoral Service Licenses UWne ICINA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA 2 WKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consultience of attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📆 No 9 ☐ Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 X Yes 2 X No 2 No 1 Tyes : After this certifical funeral director, j or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ₩ No 1 y Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident Injury 5 Pending 1 □ Yes 2 □ No after death death. investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D tiX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cauce(s) and manner as stated. 29a. Certifiar Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 28 March 2007 ance 16746 (OR) NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death Mem 2 a) (Type, Print) LEE VANCE LCDR MC USN BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) 32. Registrar's Sign State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizebeth Month **Physician** Muers 9:30 March 2007 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 9. Birthplace State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 216-36-1943 1 M 2 KF 69 Yrs. (237 UNKNOWN Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23s or 28s-1 show the Medical Examinar most be notified at Prince A delphi 1XYes 2 □ No Director Georges 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 1801 Metzerott Road USA 20783 Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unknown unk Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mental F Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Prince Georges County Area Agency on Agin

420 All entown Road, Camp princes 120th Location - City or Town, State

20th Location - City or Town, State 19a. Informant's Name/Relationship (Type, Print), ian of Gyardia Person Pages 1 and 2 nent of Health a John Claudia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ŏ Riverdale Pk Crematory March 31,07 Riverdale, MD 4 □ Donation 5 □ Other (Specify) Montgomery Cheatham Funeral Service P.O. Box 398 Upper Marlboro, MD 20773 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the diserted, or competations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physicien and detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown certificete has been signed by t rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2000 Be 25. Was case referred to medical 26. Place of Death (Check only one) Yes Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No 1 🗌 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 52326 28/2007

Division of Vital Records, P.O. Box 68760

State MAR 30 Registrar

Kennedy Lightfoot M.D 7600 Cancoll Ave. Takoma Park, MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

INK UNK	State of Maryland / Department of Health and Mental Hygiene										
		1- For State Registrar		ificate o		ia montai		eg. No.	ا تعددا کی ا		
Physicia Medical Exami		Decedent's Name (First, Middle,Last)					2. Date of Dea	th	3. Time of Death		
nedical Exam	ner	4a. Facility Name (if not institution, give	Angela Grace street and number)		er 4b. City, Town, c	or Location of De	Month April 2, 20	4c. County of De	1240 hrs		
		4708 York Road	,		Baltimore			ie. odarky dr bi	Satt		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Ye			th(MM/DD/YYYY) 9.	Birthplace (State or reign		
Director		220 11-0075 —	M 2X F	22 Yrs	Months Da	ys Hours N	Janua		85 ^{untry} Maryland		
ruy		Usual Residence of Decedent 10a. State 10b. County	10c. City, 7	Town or Local	ion				10d. Inside City Limits		
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r death with the Maryland or items 23a or 28a-f sho must be notified at once.		725 Washington				15530		U.S.A.			
ath wi	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?		is Decedent of H es, specify Cuba		Specify Yes or No rto Rican, etc.)	- 14. Race - Ar White, et	nerican Indian, Black, c.		
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36 in 72 h	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)		Ü	e. Do Nor use i	ctiled)		_		
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)		51	udent	18.Mother's Na	me (First, Middle, N	Educat Maiden Surname)	ion		
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be (Jo	hn Jacob Mey	/er		Jayne	Barefo	oot nber, City or Town, S	. <u></u>		
	2	19a. Informant's Name/Relationship (Typ	•	1							
b, MD and 2 sho tealth and item 27 is		Javne Meyer /MC 20a Method of Disposition	other 20b. Pi	ace of Dispos	ition (Name of ce	gton Sometery,	treet Bo	erlin, Pe 20c. Location - City	nnsyl 15530 or Town, State ania		
more, N Pages I and tent of Healt ant: If item		1 Burial 2 Cremation 3	_ Itemoval from State	ematory or ot	, ,		15 105				
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	Bay	ory 4 s of Facility	/5/07	Baltimor	e,Maryland				
		michael P. Margu	llo	60	09Harf	ord Ro	arzullo ad Balt	Funeral	Chapel PA		
Physician /Medical		23a. Part I. Enter the disease, or complice failure. List only one cause on each					c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death		
Examiner		The state of the s	Heroin intoxicati		cocaine us	æ			Deati		
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60, ate be ohysicie	Medi	IF FEMALE:	#25a,27,28a-f, pe	erME, go	06, 4/17/0)/ TT		23d. Date of deli	very		
687 certific nding p	sician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of dear	- =	tal death 3	Ectopic preg	gnancy	Month	Day Year		
Box 68760, e death certificate bette attending physical for use as the but	iysid	1 Yes 2 No 9 V Unknown	9 Unknown	tn 5 Ot	her (Specify)						
P.O. Box 68760, s that the death certificate be executed gned by the attending physician and e detached for use as the burial - transit	by Phy	Part II. Other significant conditions	contributing to death but not res	sulting in the i	inderlying cause	given in Part I.			to the cause of death?		
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tal Rectian: The certificate ector, page		25. Was case referred to medical			26 Blac	e of Death (Che	1 Yes	2 No 1 🗸	Yes 2 No		
Vital Rec hysician: The this certificate I director, page	o Be		spital: 1 Inpatient 2 E	R/Outpatient		Other		Residence 6 🗸 0	ther; Scene		
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Division of Vital Records, tal or Attending Physician: The law requir is after death al Director: After this certificate has been seen is ed in by the funeral director, page 2 should the funeral director, page 2 should	Certification:	3 Suicide 6 X Could not be determined	28e. Place of Injury - At hor (Specify) found in		-	building, etc.	or Town, S	tate)	Rural Route Number, City		
Di Hospital 4 hours a Suneral E		4 Homicide 29a Certifier 1 Certifying Physicia	n: To the best of my knowledge			date and place, a		k Rd. Baltin e(s) and manner as			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be deached for use as the buri	edical	one) 2 Medical Examiner:	On the basis of examination and manner stated	d/or investiga	tion, in my opinio	n, death occurre	d at the time, date	and place, and due to	o the cause(s)		
F % F 8	Me	29b. Signature and title of certifier				se number		29d. Date signed (Month, Day, Year)		
		I cosher to	1000	2	0.0	.M.E.		April 3, 2007			
d)		30. Name and address of person who co Tasha Greenberg MD. As	mpleted cause of death (Item 2 ssistant Medical Examir		Penn Street	Baltimore, I	MD 21201				
Y St	ate	31. Date filed (Month, Day Year) 2007	400								
Regist	rar	WLK T 9 COOL	SAME SA	A 19 19 19 19 19 19 19 19 19 19 19 19 19	A. A.						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. L 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Vicky Nides a_M 2007 29, March 6:19 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Director June 6, 1925 Greece 81 213-80-3232 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2X No Director Maryland Montgomery Rockville the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with a o 20853 USA 13509 Sloan Street "natural", or Items 23a dical Examiner must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 3 If Yes, Give Year or Dates: 1 Never Married 2 Married 3⊡ No ive White Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kantdiana Gianitsa George Economakis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Nides/ Husband 13509 Sloan Street, Rockville, Maryland 20853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 2, Gate of Heaven Cemetery 2007 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Edema 24 hrs /Medical Due to (or as a consequence of) Examiner 30 hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Stroke
Due to (or as a consequence of) Examiner that the death certificate be executed Atrial Fibrillation burial-trar Due to (or as a consequence of) Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Hyperthyroidism, Hyperlipidemia, Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform rmen? 2∐No 1□ Yes Vital Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 / Inpatient 2 ER/Outpatient 3 DOA Certification: To ō this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending Division 5 ☐ Pending investigation fo the Hospital or Atte.
'> 24 hours after death.
'- eral Director: Af 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical To the Hosp within 24 hor To the Fune completely fi and manner stated. 29b. Signalu 29d. Date signed (Month, Day, Year) JOSE MEXIMO IND a address of person who completed cause of death (Item 23a) (Type, Print) 30. Name ar Jose Merendino, M.D. 8600 Old Georgetown Road, Bethesda, Maryland

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 3 0

2007

139/01

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NIDES

32 egistrar's Signature

			1 - For State Registrar		laryland		artment tificate			Mental Hy	Reg. No.	007	119	23
	Physici	an	Decedent's Name (First, Middle			0.43	ZT 1737			2. Date of De	Day 28	Year	3. Time of	
	/Media		FRANCES	SMITH		UA.	KLEY					2007	10:45) A M
	Examir	ner	4a. Fecility Name (If not institution)		,	own, or Loc	ation of De	ath		ounty of Death	OD CE L	
			7911 POLK ST 5. Social Security Number	+	as /le um l	ast histoday)	GLEN	ARDEN	Jnder 24 H	Irs. 8. Date of Bi		INCE GE		
	Funeral Director		517-58-4643	1 M 2 X F	59 (<i>in yr</i> s. <i>i</i>	ast birthday) Yrs.			ours M	in. (Month, Da	ay, Year)		olace (State ontry)	ji roreigii
		22	Usual Residence of Decedent		39			1		JULY 31	1947	NEW	YORK	
	yland		10a. State 10b. County	,	10c. City	, Town or Lo	cation						I0d. Inside C	,
	Mar Mar	ţċ	MD PRINCE	E GEORGE'S		GLENA	RDEN						1X Yes	2 🗌 No
	or 28	ire	10e. Street and Number				10f. Zip C	Code			10g. Citize	on of What Cou	ntry?	
	23a	Funeral Director	7911 POLK STRI	EET				2070				U.S.A		
	r dea	ne	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S	S. 13.1	Was Decede f Yes, specif	nt of Hispar y Cuban, M	nic Origin? lexican, Pu	(Specify Yes or Ne erto Rican, etc.)	0- 14	 Race - Ameri Black, White, 		
36	s afte		1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 □ Yes 2[X No S	pecify:		5	ipecify: B	LACK	
21215-0036	72 hours after death with the Maryland natural; or Items 23s or 28e-f show Jical Examinar must be motified at	Completed by		Year or Dates:		16a Door	dent's Usual	Occupation			16h Kin	d of Business/In		
5	n 72 i "na	jete	(Specify only highe	est grade completed)		(Give	kind of work DO NOT use	done durin	g most of v	working	TOD. KIN	J OI DUSIIIOSS/II	dustry	
12	within iene. then "	E O	Elementary/Secondary (0-12) 12TH	College (1-4or	5+)	ENTR	EPRENE	UR				PRIV	ATE	
0	be filed within 72 hours after death with the Marylan ital Hygliene. ed other than "natural", or Items 23a or 28e-f show of other than "natural", or Items 23a or 23filed at event, the Madical Examinat must be notified at	a)	17. Father's Name (First, Middle,	. Last)				18.	Mother's N	lame (First, Middle	, Maiden S	umame)		
<u>a</u>	dental dental rked c	To B	JOHN MELVIN	SMITH					RACH	IEL GREGG				
Maryland	s 1 and 2 should be f Health and Mental itam 27 is marked othar traumatic ev		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Street and I	Number or	Rural Route Numb	er, City or	Town, State, Zij	Code)	
	12 F B		JAMES L. OAKL	EY SR./HUSBA					T GLE	NARDEN,			706	
ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	20b. Pl	lace of Dispo emetery, crer	sition (Name natory or oth	e of er place)		Date		ation - City or T		
Ē	Pages ment of ant: If its ury or o		`4 □Donation 5 □Other (S		ARI	LINGTO	N NATI	ONAL	4/1	•		GTON, VI		7
Baltimore,	permit. Page Department Important: If any Injury or 20008.		21. Signature of Funeral Service	-hall	J.B. Jer ad Landov				5					
		Г	23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cause	d the death	. Do not ent	er the mode	of dying, su	ich as card	liac or respiratory a	rrest,		Approximatinterval Bet	tween
	Physician	e 1	Immediate Cause (Final disease or condition	Malign		on-Sma	11 Cel	ll Lur	ng Car	ncer			Onset and	Death
	/Medical		resulting in death)	Due to (or as	s a consequ	uence of):								
	Examiner	L	Sequentially list conditions,	b										
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	uence of):								
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	s a consecu	ience of):								
8760,	ate be executed hysician and the burial-transit	icai E				.,,								
687	death certificate e attending phys of for use as the	edic	1	d.							-,-			
Box (death certifica attending ph d for use as th	Z.W.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23	d. Date of deliv	ery	
-	death a atte	iciai	in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic pred Other (spec					Month	Day	Year
0	at the de by the a	Physician/M	9 Unknown	9□ Unknown										
S,	requires that the leen signed by th hould be detache	by P	Part II. Other significant conditi	ions contributing to death	but not resu	ulting in the u	nderlying cau	use given in	Part I.	23e. Did	tobacco us	e contribute to	he cause of	death?
ğ	w require been sig should b		Diabetes Mell:	itus Type 2						- 1 -	Yes 2□	No 3 ☐ Pro	bably 4X	Unknown
Vital Record	law re has be e 2 sho	ompleted	Breast Cancer							24a. Was		24b. Were aut	psy findings	available
Œ	r: The icate har.	E O	Anemia								ormed? 2 \ No	death? 1 ☐ Yes	2 □ No	
ita	sicien: certifica rector,	BeC	25. Was case referred to medica examiner?	al				26	. Place of 0	Death (Check only				
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U C	ding Ph th. After th funeral	en:	27. Manner of Death 1 Natural 5 □ Pendi	28a. Date of Inj (Month, D	jury lay Year)	28b. Time o Injury		c. Injury at Work?		28d. Describe	how injury	occurred		
sio	Attanding r death. actor: Atter	cat	2 Accident invest	tigation			М		2 🗌 No	OOL Leasting	(044	Advise have an China	al Causa N	
Division	or Sire	ertification;		mined 280. Place of If	njury - At ho etc. <i>(Specif</i> y		eet, factory,	office			(Street and own, State)	Number or Rur	аї ноите мил	1D0r,
	pita ours aral filled	dical Ce		ing Physician: To the bes I Examiner: On the basis										s)
	유민무	Med	one) 29b. Signature and title of certifie	and manner s	stated.		29c	License nu	mber		29d. Date	signed (Month,	Day, Year)	
	To To Con		-7 - /	-7-	1.00					A #			7	
)	(nn)		30. Name and address of person	who completed source of	MD	23a) /Tupo	100	01239	ΣΟ V.	Alt	29 B	far 07		
	(20)		Kenji L. Taka:					r Rd	Andre	ws Air Fo	orce I	Base 20	762	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Regis	trar's Sign	е								
	Regist	rair	APR 02 2007	Derew D.	. Up	wer								

			for State Registrar	State o	f Marylar	•			lealth a Death	ind Me	ental Hyg	iene	007	11921
П	Fig	, de	1. Decedent's Name (First, Middle, Las	t)							2. Date of Dear	h Day	Year	3. Time of Death
	Physici /Medic		Ethel Florence	Palmer							March	29	2007	10:24 P ^M
	Examir		4a. Fecility Name (If not institution, give	street and nur	nber)		4b. Cit	, Town, or	Location of	f Death		4c. C	ounty of Death	
			Union Hospita	1				E1kt				(ecil	
1	Funeral		Social Security Number 6. Security Number	ex □ M 2 X) F	7. Age (In yrs.			er 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day)	Year)	9. Birth	place (State or Foreign ntry)
25	Director		216-52-8067	JW ZZJF		92 Yrs.	1	J			Aug. 20	, 19	14 En	gland
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	Aaryli I sho	ō					-							1 ☐ Yes 2 📉 No
	28a-	Director	Maryland Cecil 10e. Street and Number			Rising		ip Code			1	Oa. Citize	n of What Cou	ntry?
	with be or			•			10112	2191	1				ed Sta	· ·
	ns 23	Funeral	32 North Hills D		dent Ever in U	J.S. 13.	Was Dec			in? (Spec	cify Yes or No- tican, etc.)		. Race - Ameri	
0	r Her	표	1 Never Married 2 Married	Armed Fo 1 ☐ Yes	2 [X] No					, Puerto F	lican, etc.)		Black, White,	
9200-91212	be filed within 72 hours after death with the Maryland tal hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Examinar must be notified at	by	3 X Widowed 4 □ Divorced	If Yes, Giv Year or D	e ates:		1 ∐ Yes	2 💢 No	Specify:			S	pecify: Wh:	rte
2	natur	Completed	15. Decedent's Ed (Specify only highest grad			16a. Dece	dent's Us	ual Occup	ation during most	of workin	a	16b. Kind	of Business/In	dustry
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7	be filed within ital Hygiene. Ind other than event, the me		12			Hor	nemal	cer					Home	
ב	ta! H d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle, I	Maiden S	umame)	
<u>Ş</u>	should be filed within and Mental Hygiene. marked other than umatic event, the Mental Control of the Mental C	ို	Frederick G. Nou								Rose			
Maryland	2 sho		19a. Informant's Name/Relationship (7	ype, Print)			_				Route Number			
	1 and Health Iom 27 other tr		Brian F. Palmer/s	on	20h 4	33 Fo				_	Deposit		ryland	
0	Pages nent of H int: If its iry or of		1 XBurial 2 ☐ Cremation 3 ☐		State	cemetery, crei	matory or	other plac			-2007		_	
Ħ	t. Pag tment tant; I		4 Donation 5 Other (Specify		/ We	st Not					-	Colo	ra, Mar	yland
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic ODEs.		21. Signature of Funeral Service Licen	MI W	h						Foard			ne, P.A.
	Physician		23a. Part1. Inter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that cone cause on e	aused the dear ach line.	th. Do not ent RENA	ter the m	ode of dyin	ig, such as o	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	or as a consec	. ,								
ı	Lxammer	_	Sequentially list conditions, if any, leading to immediate	b. N.	w (AL	MIL	MAR	AC	4 DON			INCOL
	sit s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to	or as a consec	quence of):	20	4 -	2					INTEL
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687	physicate sthe l	ode		d										
ŏ	leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								23	d. Date of deliv	erv
ň	death atter	clar	in the past 12 months? 1 ☐ Yes 2 ☑ No		irth 2 ☐ Feta ant at time of c		⊒Ectopic ⊒ Othe <i>r (</i>	pregnancy specify)	'				Month	Day Year
o.		ys	9 Unknown	9□ Unkno	own									
J.	The law requires that the ate has been signed by th bage 2 should be detache	by PI	Part II. Other significant conditions of	ontributing to de	ath but not res	sulting in the u	inderlying	cause giv	en in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?
Records,	n sig										1 🗆 Y	es 2	No 3□ Prol	oably 4 Unknown
000	w requires been si	Completed									24a. Was a	n	24b. Were auto	opsy findings available
Ř	he lav e has age 2	E C									autops	ned?	death?	mpletion of cause of
ta	ifcian: Th certificate rector, pag	a a	25. Was case referred to medical	27.5					26 Place	of Death	Check only or	No No	1 🗆 Yes	2 No
>	Physician: The this certificate har all director, page	OB	examiner? 1 □ Yes 2 Ø No	Hospital: 1 V	npatient 2	ER/Outpatier	nt 3 🗆 [Oth Oth	or		e 5 🗆 Reside	-	Other (Speci	fv)
ō	g Phys er this eral di		27. Manner of Death	28a. Date		28b. Time o		28c. Injun Wor			8d. Describe h			77
0	Attending In death.	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		II, Day Teal)	Injury	М		Yes 2∐N	No				
Division of Vital	ul or Attending Ph after death. I Director: After th d in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place	of Injury - At h	nome, farm, sti fy)	reet, facto	ory, office		2	8f. Location (So City or Town		Number or Rur	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Direct Completely filled in I	dical	29a. Certifier 15 Certifying Ph (Check only one) 2 Medical Exam	iner: On the b	best of my knoasis of examination stated.	owledge, deat ation and/or in	h occurre vestigation	ed at the tin	ne, date and pinion, deat	d place, a th occurre	nd due to the c d at the time, d	ause(s) a ate and p	nd manner as s lace, and due t	stated. o the cause(s)
	To the within 2 To the	₩ We	29b. Signature and title of certifier				2	9c. Licens	e number		2	9d. Date	signed (Month,	Day, Year)
	F > F 0		MARAUT M	. 0 .					0467	h>	al	4.001	. 20	2.007
	0		30. Name and address of person who	completed caus	e of death (Ite	m 23a) (Type.	Print)		י טרע			Imu	17_69,	2007.
	8		MONIQUE PRATT	- WAL	WAVE		MOR	Hox	PIDA	_ 16	L BOW	ST.	ELIC	MM MOT
	Sta		31. Date filed (MPA' Pay, Year)	7 ER	egistrar's Sign		and a			4				1
1	Regist	ar	11 1 O ZUU		William July	200	PER CONTRACTOR							

			1- For State of Maryland / Registrar	Department of Health and Certificate of Death		ene 007	11925			
	Physici /Medic		Decedent's Name (First, Middle, Last) Harvey D. Piper		2. Date of Death Month March 27	7, Day 2007 Year	3. Time of Death 7:50 P. M			
	Examir		4a. Facility Name (If not institution, give street and number) 3148 Gracefield Road #201 5. Social Security Number 6. Sex 7. Age (In yrs. last by	4b. City, Town, or Location of De Silver Spring		4c. County of Death Prince Ge				
	Funeral Director		533–16–6671 132M 2 F 85 Usual Residence of Decedent	Yrs. Months Days Hours M		(ear) Count , 1921 Can	ace (State or Foreign try) ada			
	Maryland	tor		wn or Location r Spring		10	0d. Inside City Limits 1 ☐ Yes 2 X No			
	th with the 23a or 286	ai Direc	10e. Street and Number 3148 Gracefield Road #201	10f. Zip Code 20904	, -	Citizen of What Count Jnited State	•			
900	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28e-f show eny injury or other treumatic event, the Medical Examinar must be notified Once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 1 Never Norced 1 Never Married 2 Never Norced 1 Never Norced 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Norced 1 Never Norced 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Norced 1 Never Nor	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 □ Yes 2 ☒ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e Specify: Whi	etc.			
21215-0036	I within 72 h iene. r then "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	a. Decedent's Usual Occupation (Give kind of work done during most of v life. DO NOT use retired) Officer	vorking 16	b. Kind of Business/Ind	lustry			
Maryland 2	uld be filed Vental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Frank Milton Piper		lame (First, Middle, Ma a Frances E					
	and 2 sho salth and h n 27 is ma er treuma			b Mailing Address (Street and Number or 567 Holman Avenue,						
Baltimore,	it. Pages 1 arment of He rtant: if item		1 Burial 2 Cremation 3 Removal from State	of Disposition (Name of Sycamatory or Other place). Wash. University Maial Center 22. Name and Address of Facility C	rch 27 2007 Wa	shington,	D.C.			
Ba	Depa Impo eny is		Estuda Gred	P.O. Box 58007 W	ashington,	D.C. 20037	•			
la de la companya de	Physician /Medical		23a. Par1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence	-ive heart fa	lac or respiratory arrest	rom	Approximate Interval Between Onset and Death			
8760,	icate be executed by physicien and burial-transit b	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen	l reguract	Horis Hon					
.O. Box 6	The law requires thet the death certifica ate hes been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	h 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver	ry Day Year			
ο,	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death? ably 4 Unknown			
Vital Records,	icien: The law recertificate hes berector, page 2 sho	Completed	25. Was case referred to medical	20.00		prior to con death?	osy findings available inpletion of cause of			
\equiv	Physicien: this certificatal director, I	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/C	Other	Death (Check only one) Home Death Residence	ce 6 ☐Other (Specify				
Division of	ding After fune			Time of Injury at Work? M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how		,			
Divis	Hospital or Attanova to hours after death Funeral Director: tely filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	arm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	l Route Number,			
	To the Hospital or within 24 hours after for the Funeral Direction completely filled in I	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge on the basis of examination a and manner stated.	ge, death occurred at the time, date and pland/or investigation, in my opinion, death or	ice, and due to the caus curred at the time, date	se(s) and manner as sta a and place, and due to	ated. the cause(s)			
)	To the I within 2 To the I complet	Z	29b. Signature and title of certifier Puthumang	29c. License number D 59524		Date signed (Month, L CINCH 30				
2	-			(Type, Print) OGRACEFIELD RO	AD, SILVE	RSPRING	MD2090L			
	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 0 2007 Signature 32. Registrar's Signature	v .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 26, 2007 **Medical Examiner** William Lee Quade 1010 hrs 4a. Facility Name (if not institution, give street and number) c. County of Death b. City, Town, or Location of Death Howard 9205 Burley Lane Laurel 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7, Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. **Funeral** oreign Florida Months Davs Hours 4/15/1943 Director 214-42-4147 63 1XXM 2 F Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 X No 23a or 28a-f show notified at once. Howard Savage MD with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20763 9205 Burley Lane Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 11. Marital Status 12 Was Decedent Ever in U.S. or items. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene Never Married 2 1X Yes Yes, Give Year Vietnam White Yes 2 X No specify: 4 X Divorced Specify: Widowed of Health and Mental Hygiene If item 27 is marked other than "natural", her traumatic event, the Medical Examiner à 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) NASA 21215-0036 4 Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lorene Sullivan William Quade 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15102 Cidar Wood Ct. Silver Spring, MD 20906 Aaron Quade 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) or other 1 Burial 2 XX Cremation 3 Removal from State Pages 1 4/6/2007 Baltimore, MD Metro Crematory 4 Donation 5 Other Specify 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Head and neck injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last ing physician and as the burial - transi The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 27, 28a-f, perME, g867, 5/4/07 TT Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ≦ 1 Yes 2 No 3 Probably 4 V Unknown σ. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No ✓ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital æ examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Qutpatient 3 1 🗸 Yes No 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification Natural 1 Yes 2 X No Pending unknown Director: d in by the f Fnd 3/26/2007 Fnd 10:05 am 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)
9205 Burley determined (Specify) 24 hours a Funeral 1 found at home Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCMF. March 27, 2007 11, 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. egistrar's Signatu 31. Date filed (Month, Day, Ygar) APR 1 0 2007

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200^{Year} **Physician** Month Day 1:00 Рм Joseph Leonard Quade, Sr. April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 23349 Hurry Road St. Mary's Clements If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1XM 27 F 86 219-12-4946 Director December 14, 1920 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notifled at St. Mary's Maryland Clements 1 ☐Yes 2X No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23349 Hurry Road 20624 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator U.S. Government p.rmit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, the ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (James Carroll Quade, Sr. Grace Irene Lacey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Estelle Quade / Wife P.O. Box 252 Clements, MD 20624 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Bushwood, Maryland Sacred Heart Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. P. 11. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician IN /Medical Due to (or as a consequence of) Examiner 1273e Zheimer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has be irector, page 2 s autopsy performed 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 Yes 2 No 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00506 30. Name and address of person who completed cause of death (Item 23a) (Type/Print) Leon W. Berube, M.D. 28170 Old Village Road Mechanicsvi'lle, MD 20656 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 0 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	larylan				ealth a	and M		giene Reg. No.	2007		928
		- 1	Decedent's Name (First, Middle, Last	(t)			mou		Journ		2. Date of Dea		Lus W W I	3. Time of E	Death
	Physici	an	Tal D								Month	Day	Year		М
- 1	/Medic	_	John KI	V22			41 07	-	1	. D 45	March		2007	2234	
1	Examin	ier	4a. Facility Name (If not institution, give						Location o	t Death		-	County of Death		
			Anne Arundel Me					lapo.	lis If Under 2	24 Ure	O Date of Birth		ne Aru		F
	Funeral		5. Social Security Number 6. S	ex 1 7 .M.2□F /.A		last birthday)	Months		Hours	Min.	8. Date of Birth (Month, Day	r, Year)	Cou	place (State or intry)	Foreign
	Director		220-34-9424	A		68 Yrs.				Ч	une 13	3 19	38 Mar	yland	
	pug s		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City	Limits
	sho sho	5			_									1X□Yes	
	8a-f	ect	Maryland Anne A	rundel	A	nnapo						10 0:1:			
	ith the	Director	10e. Street and Number				10f. Zi	p Code				iog. Citiz	en of What Coเ	intry ?	
	ath v	Funeral	3516 Cohasset 2					2140				US			
	r de	rue	11. Marital Status	 Was Deceden Armed Forces 	?	S. 13. \	Was Dece f Yes, spe	dent of Hi cify Cuba	spanic Origin, Mexican	gin? (Sp∈ i, Puerto	ecify Yes or No- Rican, etc.)	1	 Race - Amer Black, White 		
98	or i		1 Never Married Married	1 ☐ Yes 2 🔀 If Yes, Give	No		1 ☐ Yes	2 √ □ No	Specify:				Specify: B1	ack	
5-0036	ural"	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:											
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2121	ithin nan '	ldu	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT L	ise retired)			Ann	e Arun	del Co	
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nd	al H	Be	17. Father's Name (First, Middle, Last)								e (First, Middle,	Maiden S	Surname)		
<u> </u>	Men arker	2	Albert Russ						Mary	, Jc	hns				
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (al Route Numbe				
	Health Health Iem 27 i		Shirley Russ(W	ife)							nnapo1				
<u>S</u>	of Her		20a. Method of Disposition	Romoval from State	20bH	lace of Dispo	sition (Na	me of other plac			Date	20c. Loc	ation - City or T	Town, State	
Baltimore,	Pages nent of h ant: if ite		(3-30	0-07	Ann	apolis	, Md.	
a	그 는 끈 글		21. Signature of Funeral Service Licer	isee		W	nName P	% /	of gacilie	Sons	Mortu	ary	, P.A.		
m	Depar Impor any ir		Lavy M. A	esse MOC	483						apolis			01	
			23a. Part1. Enter the disease, or com	plications that cause	ed the death	n. Do not ent	er the mo	de of dyin	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Betw	roon.
4	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each	ine.	1,0	21	10	100.					Onset and D	eath
1	/Medical		disease or condition resulting in death)	a. Due to or a	s a consequ	ience of):	22-67	The		7				4000	
	Examiner			1	trist	h	4							CKS	
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequ	uence of):								7,	
	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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687	icate phys	dic		d											
	death certifica attending pt d for use as t	/Me	IF FEMALE:	23c. If yes, outcom	e of pregna	ncv							3d. Date of deli	10n1	
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant	2 Feta	Ideath 3	Ectopic p	regnancy				2	Month	*	ear
	the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time or d	eath 5L	J Other (s	респу/							
P.0	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit		Part II. Other significant conditions of	ontributing to death	but not rest	ulting in the u	nderlvina	cause give	en in Part I.		23e. Did to	bacco us	se contribute to	the cause of de	eath?
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Vital	nysician: Thatis certificate director, pag	Be (25. Was case referred to medical examiner?						26. Place	of Death	n (Check only o	пе)			
or/	ys dir	10	1. Yes 2 No			ER/Outpatier			4 LI NU	rsing Ho	me 5 Resid	lence 6	□Other (Spec	eify)	
	fer fer		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D		28b. Time o		28c. Injury Work	y at </td <td></td> <td>28d. Describe h</td> <td>now injury</td> <td>occurred</td> <td></td> <td></td>		28d. Describe h	now injury	occurred		
Sio	Attending r death. ector: After by the funer	ätic	2 ☐ Accident investigation				М		Yes 2 □ I	No					
Division	ier de lirect	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	200. Place of it	njury - At ho etc. <i>(Specif</i>	ome, farm, str v)	eet, facto	ry, office			28f. Location (S City or Tow	Street and vn, State)	l Number or Ru	ral Route Numb	oer,
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	hou une une	cal	29a. Certifier Certifying Ph	ysiclan: To the bes	t of my kno of examina	wledge, deat	h occurre	d at the tin	ne, date an	nd place, ath occur	and due to the	cause(s)	and manner as	stated.	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical	one)	and manner s											
	with Volume	Σ	29b. Signature and title of certifier				29	c. License	number			29d. Date	e signed (Month	n, Day, Year)	
	1		Y Miller	un				1150	168			03	- 26	200/	
-	5		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Prip#)		fr.	10	des, M	(11) - (/	75 3	
			John Jarles	1 200	3 00	ird	1 Kg	/ /	o M	ge	ous, /		1214	0/	
	Sta	ate	31. Date filed (Month, Day, Year)	Regis	trar's Signa	ture	and s								

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Christine Mary Rock 9:53 Ам March 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17465 Poplar Street Piney Point St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 13, 1918 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 F 88 577-10-1498 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland 1 ☐ Yes 2 X No Director St. Mary's Piney Point 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 17465 Poplar Street 20674 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professional Manager Housing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wesley Henderson Roberta Anne Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. Shirley Anne Rock / Daughter P.O. Box 411, Piney Point, Maryland 20674 20b. Place of Disposition (Name of cemetery, crematory or other place St. George's Catholic Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2, 2007 Valley Lee, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Michael P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that call see the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death ATHEROSCIE ROTIC Immediate Cause (Final CARDIONITSCULAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) s been signed by the sahould be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PULMENTA 1 Yes 2 No 3 Probably 44 tonknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform 2 No 2□ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation within 24 hours are: To the Funeral Director: After a serion of the funeral of t 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State

Medical

4 Homicide

(Check only one)

31. Date filed (Month

29b. Signature and tife of certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

SMAH ASSOCIATES, MOLYWOOD, MI) 20636

29d. Date signed (Month, Day, Year)

Hospital or Attending completely within 24

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title oncertifie 32. Registrar's Signatu

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200 PM

Birthplace (State or Foreign Country)

D.C.

10d. Inside City Limits

1 ☐ Yes 2 No

Wash.,

Black, White, etc.

21114

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

20715

Approximate Interval Between Onset and Death

max

Year

4 Unknown

White

State Registrar 07-02514 Terri L. Ramsey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erri L. Ramsey	1	State of Maryland / Department of Health and Men 1- For State Certificate of Death	ital Hyg		ti-	200	/ 1193					
Physicia		Registrar 1. Decedent's Name (First, Middle, Last)	2.	Date of Deat	g. No. h		3. Time of Death					
Medical Examin		Terri I. Ramsey		Month April 2, 20	Day	Year	0925 hrs					
draw.		Terri L. Ramsey 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of		· · · · · · · · · · · · · · · · · · ·		unty of Deat	h					
		Prince George's County Hospital Cheverly			Prin	ce Georg	e's					
Funeral		Months Days Hours	er 24Hrs.	8. Date of Birt	th (MM/DD/	YYYY) 9. Bi Forei	rthplace (State or gn District					
Director	L	578-92-4769 1 M 2 F 41 Yrs. Yrs.		Augus	st 8.	1965	Columbi					
20		Usual Residence of Decedent 10a. State UNKJ0b. County UNK nown 10c. City, Town or Location					10d Inside City Limits					
Maryland 28a-f show any d at once.		unknown					1 Yes 2 No					
aryland 8a-f sho at once.	핡	10e. Street and Number 10f. Zip Code		110	On Citizen	of What Cou						
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ier de ", or er mı		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	:		Spe	ecify: B	lack					
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5-0 iled w Hygid I other			·	irst, Middle, N								
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D 2 Shoul and M 7 is m	_	Patricia Ramsey/Mother 3401 Gennene Ln										
imore, MD 2 Pages 1 and 2 shou ment of Health and I land: If item 27 and or other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		ate Was			Town, State					
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Baltimore, permit Pages I ar Department of He Important: If ite injury or other tr	-											
Baltimo permit Page Department o Important: injury or oth	4	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Strickland Funeral 6500 Allentown Rd. Camp Spring										
Physician	\exists	23a. Part I Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
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6 be executed ysician and burial - transit	edical	X UNPENDED #23a, perME, g86/,5/8/0/ TT #23a, 27, 28a-f, perME, g866, 4/17/07 TT					10					
766 ficate g phys the b	ğ [IF FEMALE: 23c. If yes, outcome of pregnancy	ic pregnanc	.,		ate of deliver	y Day Year					
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ords	Completed			24a. Was autop	sy	prior to	utopsy findings available completion of cause of					
(eco) he law ate has	E			perfor	med? 2 No	death? 1 ✓ Y	es 2 No					
Vital Rec ysiciau: The his certificate director, page	Be C	25. Was case referred to medical 26.Place of Death	(Check on	ly one)								
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ision Attend or death. rector: by the f	اۋز ا	2 Accident Investigation Fnd 4/2/2007 Fnd 8:20 am		unknown								
ivis lor A after Direction by	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, et	etc. 2	8f. Location (S or Town, S	Street and tate)	Number of R +1 Benn:	ural Route Number, City ing Rd N.E.					
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	iga	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plat (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death oc										
To t To t	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number					onth, Day, Year)					
	-	O.C.M.E.			April 3	, 2007						
	-	30. Name and address of person who completed cause of death (Item 23a)										
AC.		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, I	MD 2120	01								
Sta	ate	31 Date filed (Month, Day, Year) 32. Registrar's Signature										
Registi												

State of Maryland / Department of Health and Mental Hygiene	211		
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eonel Ramirez-Ar		Sta - For State	mend Item 3		hent of Health cate of Death	and Mental I	lygiene	2.00	7 1 532	
Physician Medical Examine	/ 1	edistrar Decedent's Name (First, Middle LEONEL	RAMIR		ARIAS	<u> </u>	2. Date of Death Month D March 24, 2		3. Time of Death 1940 hrs	
	4	4a. Facility Name (if not institution, give street and number) 711 Nova Ave			4b. City, To	vn, or Location of Dear Heights				
Funeral Director	Se N. Co	30 Yrs. 106/10/1950							Sirthplace (State or eign ZL Country) 3 AL VA DOR	
death with the Maryland or items 23a or 28a-f show any must be notified at once.	1	Joual Residence of Decedent Oa. State Do. Street and Number 7// NOVA	G. CAPIT AVE		PITOL 10f. Zip C			Citizen of What Co	10d. Inside City Limits 1 Yes 2 No	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once	2115	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			If Yes, specify Cuban, Mexican, Puerto Rican. 1 Yes 2 No specify: SALU 16a. Decedent's Usual Occupation (Give kind of work of during most of working life. DO NOT use retired)			MAPOR Specify: HIS PAHIC one 16b. Kind of Business/Industry		
y, MD 21215-0036 and 2 should be filed within 72 hours after teath and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner. To Be Completed by 1	3	7. Father's Name (First, Middle,	ARIAS		9b. Mailing Address	18. Mother's Nam	e (First, Middle, Mai	iden Surname)	RUCTION MIRE Z te Zip Code)	
Baltimore, MD; permit. Pages I and 2 shou Department of Health and Important: If item 27 is injury or other traumaric	2	VIKGILIA HKIAS 4258 BUCKMAN RV #39 HLE							or Town, State VA VA VA VA VA VA VA VA VA V	
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). Box 68760, the death certificate by the attending physic ched for use as the bur Physician/Mec	II 23	F FEMALE: 8b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unki	4 Pregnant at t		y 2 Fetal death 5 Other (Specify	3 Ectopic pregr		23d. Date of delive Month	Day Year	
Records, P.C. The law requires that ficate has been signed r. page 2 should be deter Completed by	fa paradimos	eart II. Other significant conditions are in the significant conditions.	contributing to death	but not result	ing in the underlying ca		1 Yes 24a. Was an autopsy performe 1 Yes 2	2 No 3 Property No 3 Property No 4 Property		
Division of Vital pital or Attending Physician our after death. Ineral Director: After this certifiled in by the funeral director. Certification: To Be		examiner? 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Other 4 Nursing Home 5 Residence 6 Vertex Norsing Home 5 Residence 6 Vertex Nursing Home 5 Residence 6 Vertex Norsing								
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune Medical Certification:		2								
T. S. T. P. S. D. M. C. D. M. C. D. M. C. D. C.	L	29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)					1	29d. Date signed (Month, Day, Year) March 25, 2007		
State	e 3	Margarita Korell MD. 11. Date filed (Month, Day Year) NAR 3 0 2007	Assistant Medical I			et, Baltimore, MD	21201			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 10:25 PM Esther Magdalene Shupp APRIL 04 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown
If Under 1 Year | If Under 24 Hrs. Washington Washington County Hospital Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F Director 78 September 10,1928 MD 213-24-8640 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner πust be notified at 1 ☐ Yes 2 No Director MD Washington Big Pool 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21711 USA Completed by Funeral 12734 Pecktonville Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 □ Yes 2 No Specify Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home R permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other th any injury or other traumatic event, tha 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Alice Pearl Hull Nevin Luther McCarty, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12734 Pecktonville Road Big Pool, MD 21711

ce of Disposition (Name of Date 20c. Location - City or Town, State Harry E. Shupp/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 04/10/07 Hagerstown, MD Cedar Lawn 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sephic 8hb Due to (or as a consequence of): Shock /Medical Examiner callulation of both necrohanne Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transi stape Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Veat 4□Pregnant at time of death 5 ☐ Other (specify) detached for 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 □ Yes 2 □ No 2001 25. Was cas referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ Ne 1 Impatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 ☐ Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 2007

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Year,

APR 1 3 2007

			1 - For State Registrar	State of M	larylar	-			lealth a Death	ind M		giene Reg. No	211117	11934
	Physici	3 m	1. Decedent's Name (First, Middle, Las	t)							Date of Dea Month	Day	/ Year	3. Time of Death
	/Medic		Agnes O. Sanf								March	2.7	,2007	5:30p [™]
	Examin	er	4a. Facility Name (If not institution, give)		4b. City	, Town, or	Location o	f Death		4c.	County of Dea	th
			Union Hospi 5. Social Security Number 6. Se		an /In vre	last birthday)		kto r 1 Year	n If Under 2	24 Hrs	8. Date of Birt	b	Ceci1	thplace (State or Foreign
	Funeral Director			M 2 □ F	88	Yrs.	Months		Hours	Min.	May 1	Year)	918	PA
			Usual Residence of Decedent				1							
	show		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	the Mar 28a-f s	ctor	MD Cecil		E1	kton								1 ☐ Yes 2 📆No
	ith with the Maryla 23a or 28a-f shov ust be notified at	Director	10e. Street and Number				10f. Zi	p Code				10g. Cit	izen of What C	ountry?
		rai	40 Highland Av					192					U.S.	
	er de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	I.S. 13.	Was Dece If Yes, spe	edent of Hi ecify Cuba	ispanic Orig In, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi	
36	hours after tural', or its	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X If Yes, Give Year or Dates:			1 🗌 Yes	2 ∏⁄ No	Specify:				Specify: W	hite
8	72 hours after der "natural", or items olical Examination		15. Decedent's Ed	ucation	•	16a. Dece						16b. K	ind of Business	/Industry
15		piet	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or	5+1	(Give	kind of w	ork done d ise retired	during most I)	of workii	n g			
21	d with	Completed	12	2.	J+)	Sec	reta	ry				E	ducati	on
ᅙ	al Hy I other	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
a a	Ments Ments arked	ည	Frank Owen						Cha	arlo	tte Jo	ones	8	
Maryland 21215-0036	2 sho and is mu		19a. Informant's Name/Relationship (7	,									r Town, State,	
	and lealth m 27	1	Pam Herglotz/D	aughter	005				ourt				osa,	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Maharal Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Ille Mannes.		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State		Place of Disponentery, cre-	matory or	other plac		Anri	1 14,		ocation - City or	
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3a	Depar Depar Impor Eny in		21. Signa bre of Faulury British licen	S00					ss of Facility	•	uneral	l Ho	nme	
	do E e d		23a. Part1. Enter the disease, or comp	The tions that saves	nd the deal									2 1.9.2 1
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each	line.	Tuence of):		ue or dyni	y, such as			1651,		Interval Between Onset and Death
	/Medical Examiner		1	Due to (or a										
/	<u>\$</u> ,	5	Sequentially list conditions, if any, leading to immediate	Due to (or a										
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ć,	be executed icien and burial-transit	Еха	resulting in death) Last	Due to (or a	s a conseq	quence of):								
8760,	ate be ex hysicien the buria	dical		d										
9	certificate Iding phys	0 1										- 1		
		Physician/M	23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			∃Ectopic p	regnancy				104	23d. Date of de	,
	D 00 D	sici	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant a 9☐ Unknown			Other (s			<u> </u>			Month	Day Year
P.0	tac by	Phy	9 Unknown								20. 5:44	1		4.4.40
	8 5 8	Ď	Part II. Other significent conditions co	onthouting to death	but not res	suiting in the u	naeriying	cause give	en in Paπ I.			obacco u fes 2		o the cause of death?
or Or	w requires been sign should be	Completed										185 21	5140 201	
ě	62 CA	ldu									24a. Was autop	SV	24b. Were a	utopsy findings available completion of cause of
픋	page 1											rmed?		s 2 No
V:E	Physician: 1 this certificel rat director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othe	0.00		(Check only o			
o	Phys this rat dii	. T	1 Yes 2 No	28a. Date of Inj		28b. Time o		UA	4 🗆 140		me 5 Residence 128d. Describe h		6 Other (Spe	ecify)
S C	ding I h. After funer	盲	1 Natural 5 ☐ Pending	(Month, D	ay Year)	Injury	м	28c. Injury Work	k? Yes 2 ∐it	1	Edd. Describe i	io n iriju	y occurred	
Division of Vital Records,	Attending in death. Sector: After by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ir	njury - At h	ome, farm, st					28f. Location (5	Street an	d Number or A	ural Route Number.
Š	efter Ofre d in b	erti	4 Homicide	building, e	itc. (Speci	fy)		,,			City or Tox	vn, State)	
	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	aic	29a. Certifier 12 Certifying Ph	ysician: To the bas	t of my kna	rwhedge, deat	h odnume	ot the fin	ne, data an	d plane, t	and due to the	tauea(e)	NETWORK AND A STANK	e etatod.
	n 24 l	edicai	(Check only 2 ☐ Medical Examone)	iner: On the basis and manner s	of examina	ation and/or in	vestigation	n, in my o	pinion, deal	th occurr	ed at the time,	date and	place, and du	e to the cause(s)
	To 11 withii To 11 comp	Me	29b. Signature and title of certifier	10			29	c. License				29d. Da	te signed (Mon	th, Day, Year)
			- HAMPANA TO	Ulan Her	D			DODL	034 6°	7			3/30	107
	6		30. Name and address of person who o	completed cause of										21921
_/	U .		VANESSA VILL	KE, WD			MR.	HILL	DIRI	UE	el V	4 DK	, Imp	41-141
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ature								

STIMA

30. Name and didress of person who completed cause of death (Item 23a) (Type, Print)

CYNTHIA M. WILLIAMS, DO 6001 MUNCASTER MILL RD., ROCKVILLE, MD 20855

31. Date filed (Month, Day, Year)

APR 0 2 2007

State Registrar

			1 - For State Registrar	State of M	aryland	•	tificate of D		, ,	iene _{eg. No.} 2 ()	07 11930	_
	Physicia /Medic		Decedent's Name (First, Middle James Kevin :	. ,					2. Date of Deal	Day 20	Year 1202A M	1
	Examin		4a. Facility Name (If not institution				4b. City, Town, or L	ocation of Death	1	4c. County	of Death	_
			Doctor's Commu	nity Hospital			Lanha			Prin	ce George's	
l.	Funeral Director		5. Social Security Number 577-54-7834	6. Sex 7. Ag 1 🕱 M 2 🗆 F	je (In yrs. lasi 65	t birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, November	Year)	9. Birthplace (State or Foreign Country) District of Columb	
	land ow t		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Loc	cation				10d. Inside City Limits	3
	Mary a-f sho fied a	tor	Maryland Prince	George's			Beltsville				1 ∐Yes 2x No	ì
	th the or 28¢ e noti	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	/hat Country?	
	23a ust b		4402 Yucca	Street				20705			.S.A.	
30	be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Mari 3 □ Widowed 4 □ Divorced	If Yes, Give			Vas Decedent of His i Yes, specify Cuban ☐ Yes 2 1 No	panic Origin? (S , Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		e - American Indian, k, White, etc. White	
-00036	thour atural		15. Deceden	t's Education	1.1	16a. Deced	ent's Usual Occupat	tion		16b. Kind of Bus		
<u>ر</u>	hin 72 9. an "na Media	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4or	5+)	(Give life. L	kind of work done du OO NOT use retired)	ıring most of wor	rking			
7	e filed within al Hygiene. I other than ' vent, the Me	Com		2	,	C	omputer Spec				d Bank	
and	be filed ntal Hygi od other event, tl	Be	17. Father's Name (First, Middle,	_					ne (First, Middle, I		9)	
<u> </u>	should by and Ments s marked umatic ev	٩	Thomas Costell 19a. Informant's Name/Relations			10h Mailin	g Address (Street ar		Frances Ke		04-4- 7-0-4-	_
<u> </u>	id 2 sho Ith and 27 is ma trauma		Joan C. Sheehan				Yucca Street					
ก	s 1 and 2 f Health item 27 other tr		20a. Method of Disposition	- spouse	20b. Plac	e of Dispos	sition (Name of natory or other place	1			City or Town, State	_
Ē	trent of tant: If it it it it or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🗷 Other (S			-	eaven Cemete	í i .	L/2007	Silver Sp	oring, Maryland	
Daltimor	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once.		21. Signature of Funeral Service	Licensee	1	l H	. Name and Address ines-Rinaldi	Funeral	Home, Inc.	er Snring	, Maryland 20904	_
6			23a. Part1. Enter an ease, or shock, leart failure. List	complications that caused	d the death. I						Approximate Interval Between	_
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. Metast	atic Lu	ng Can					Onset and Death	
	Examiner			Due to (or as	a consequen	ice oi):						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as	a consequen	nce of):						
	ecutec nd transi	Examiner	Cause (Disease or injury that initiated events	с								
20	oe execian a	E	resulting in death) Last	Due to (or as	a consequen	nce of):						
00/00	physicate to the the the the the the the the the the	edical		d								_
X	certifi nding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d Date	e of delivery	
.O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months? 1 Yes 2 No 9 Unknown	1⊡Live birth 4⊡Pregnant a 9⊡Unknown	2 Fetal de	eath 3⊑	Ectopic pregnancy Other (specify)			Mor	*	
Ţ	s that ned b e deta	by Pr	Part II. Other significant condition	ons contributing to death b	out not resulting	ng in the ur	derlying cause giver	n in Part I.	23e. Did tot	acco use contri	ibute to the cause of death?	
SDIODA	equire en sig ould b	ed b	Brain Metasta	ses					1 □ Ye	es 2 No	3 ☐ Probably 4 ☑ Unknown	٦
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200	tending eath. or: After the funer	Certification:	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	ng (Month, Da gation	ay Year)	Injury		es 2 🗆 No	28d. Describe ho	iw injury occurre	;a	
2	tal or At s after d al Direc ed in by	Certifi	4 ☐ Homicide determ	pined 28e. Place of Inj	tc. (Specify)	e, tarm, stre	eet, factory, office		28f, Location (St City or Town	reet and Numbe n, State)	er or Rural Route Number,	
	ne Hospi' n 24 hour ne Funer	Medical	29a. Certifier 1	ng Physician: To the best Examiner: On the basis of and manner st	of examination	edge, death n and/or inv	occurred at the time restigation, in my opi	e, date and place inion, death occu	e, and due to the curred at the time, d	ause(s) and mar ate and place, a	nner as stated. and due to the cause(s)	
	Withir C Comp	Ř	29b. Signature and title of certifie	allt	~~		29c. License	number	2		(Month, Day, Year)	
			30. Name and address of person	·			Print)		abolt Mac			_
	0.		Martin Weltz, N 31. Date filed (Month, Day, Year)		nway Cen rar's Signatur		ive, Suite	zuo, Green	wert, Mary	1and 207	70	_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day March 28, 2007 0905 Sharma 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 12/2/1952 530-84-5251 India Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🖫 No Maryland | Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10312 Coniston Court 20854 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Base 2 Elementary/Secondary (0-12) College (1-4or 5+) Computer Scientist Technologies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rajendra Sharma Savitri Sharma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neena Sharma - wife 10312 Coniston Ct., Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial 3/29/2007 | Fairfax, VA 22. Name and Address of Facility Fairfax Memorial 9902 Braddock Rd., Fairfax, VA 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sisto lux mousky Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): MULTI SUSTIM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) MOMSMIR Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performe 2 No

Physician /Medical Examiner

Box 68760.

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Records,

Division or Vital or Attending Physician:

law requires that the death certificate

Physician

/Medical

Examiner

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

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Certification:

Medical

death with the Maryland

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

and I

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is

injury or

signed by tage certificate within 24 hours after death

To the Funeral Director:
completely filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1∐ Yes 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

1 Yes 2 No 27. Manne of Death 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

25. Was case referred to medical

29b. Signature and title of certifier

examiner?

28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

> 29c. License number 00052774

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAR 3 0 2007

SUBURN INSPAIN 32 Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year а м McHugh Stuart, Jr. 28, 2007 /Medical March 9:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Yrs Director 577-18-1526 90 April_21, New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 ☐ No Maryland Montgomery Chevy Chase Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 9001 Clifford Avenue 20815 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ SpecifWhite 3 ☐ Widowed 4 ☐ Divorced 'natural" 1941-44 Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Foreign Service Officer Federal Government other i 17. Father's Name (First, Middle, Last) Be 18, Mother's Name (First, Middle, Majden Surname) Ith and Mental F 27 is marked of traumatic even Pages 1 and 2 should be John McHugh Stuart Marie Fitzgerald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Charles F. Stuart, Jr./Nephew 9001 Clifford Avenue, Chevy Chase, MD 20815 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. March 29 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Address of Tins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 annes 23a. Part Enter the disease, or complications that exped the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Lines traditions in injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed Congestive Heart Failure physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical Myocardial Infarction as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death Month Year 5 Other (specify) P.O. 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Division or Vital 28 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2000 No Certification: To this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending F after death. (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital or within 24 hours at To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year) K 9758876 07

State Registrar

31. Date filed (Month, Day, Year)

WAR 30 2007



Noialid Sillilli		1- For State	31	ate of Maryl		artment o e <i>rtificate o</i>			Mental			200	1 1193
Physicia		Registrar 1. Decedent's Nam	e (First, Midd	le,Last)		Timodio o	Dean	<u></u>		2. Date of De			3. Time of Death
Medical Exami	ner		ROLANI		SMIT	ГН				Month March 26	Day 5, 200 7	Year	1945 hrs
		4a. Facility Name (Southern M			umber)		4b. City, T Clinto		ocation of De	eath		County of Deat rince Georg	
Funeral Director		5. Social Security N		6. Sex	7. Age (In yrs. 42	last birthday) Yrs	Months	r 1 Year Days	If Under 24 Hours	Hrs. 8. Date of E		Forei	rthplace (State or gn MARYLAND ountry)
		Usual Residence of	f Decedent					 -					
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urs aft	ā.			or Dates: cify only highest gra		16a. Deceder	Yes 2			of work done		Specify: ind of Business	BLACK /Industry
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21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	17. Father's Name RUSSELL	J. SM	TH SR.					ANNIE	me (First, Middle, M. CARR	COLL		
ore, MD 2121: es 1 and 2 should be fil of Heath and Mental P If iten 27 is marked] ٢	19a. Informant's Na ANN M.		hip (Type, Print) SISTER		19b. Mailin 6812	g Address KIPL	(Street a	and Number of PARKWA	or Rural Route Nu Y DISTRI	ımber, Cit CT H	y or Town, State EIGHTS ,	e, Zip Code) MD 20747
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Baltimo permit Page Department o Important: injury or oth	ŀ	4 Donation 5 21. Signature of Fu			7	LINCOLN 22.1	CEME Name and			/2/2007 T B			MARYLAND ERAL HOME
Den Den in in in in in in in in in in in in in		K.1	· M-	hall		-	7474	LAND	OVER R	OAD LAND	OVER	,MARYLA	ND 20785
Physician / / / / / / / / / / / / / / / / / / /		23a. Part I. Enter th failure. List on	e disease, or ly one cause	complications that on each line.	caused the death	n. Do not enter t	he mode o	f dying, si	uch as cardia	c or respiratory a	rrest, sho	ck, or heart	Approximate Interval Between Onset and
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3760, ficate be g physici		IF FEMALE: 23b. Was decedent	pregnant in th	23c. If yes,	outcome of preg			2	7 545- 15-1-1			Date of deliver	,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/	past 12 months 1 Yes 2 N			nant at time of d	ooth =	etal death ther (Spec	3 ify)	Ectopic preg	gnaricy	li)	Month	Day Year
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Divi Hospital or 24 hours afte Funeral Dir	Certification:	3 ✓ Suicide 4 Homicide		a not be	garage					or Town,	State)	t, Clinton, MD	arai Roace Namber, Orty
Divi: To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(or our or m)		nysician: To the be miner:On the basis and manner:	of examination								
E 3 E 8	Me	29b. Signature and	title of certifie		111		29c.	License				ate signed (Mo	onth, Day, Year)
0 (2)	-	30. Name and addre	ess of person	who completed cau	ise of death (Iten	n 23a)		O.C.M	.c.		iviard	ch 28, 2007 	
P (3)		Melissa Bra	ssell, MD	Assistant Me	edical Exami	ner 111 F	Penn Str	eet, Ba	ltimore, M	D 21201			
Sta Regist	ite	31. Date filed (Mont	h, Day Year)	32. R	egistrar's Signat	ura							

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01-02321	

Robert Bismark		1- For State Certificate C	of Health and Mental F	lygiene	2017 1105						
Physici Medical Exami	an/	1. Decedent's Name (First, Middle, Last) Robert Bismark Sanders		Reg. 2. Date of Death Month D March 26, 26	3. Time of Death						
		4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of Deat Cheverly	h	4c. County of Death Prince George's						
Funeral Director		5. Social Security Number 6. Sex 1 X M 2 F 5.9 Yr.	If Under 1 Year If Under 24Hr Months Days Hours Mil	n.	MM/DD/YYYY) 9. Birthplace (State or Foreign						
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygiene nnt: If item 27 is marked other than "natural", or items 23a or 28a-f show any r other traumant event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 1 Armed Forces? If 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decede	In the control of the	US Specify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black Sb. Kind of Business/Industry Private						
21215 buld be file Mental H marked o	To Be (Cleophus Sanders 19a. Informant's Name/Relationship (Type, Print) (1944) 19b. Mailin	Charlo		abeth Webster						
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thingury or other traumatic event, the Med		Porchia Cassandra Powell 504 20a. Method of Disposition 20b. Place of Dispo	62nd Pl #D, o	Capitol	Heights Md 20743 Oc. Location - City or Town, State						
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 K Burial 2 Cremation 3 Removal from State Quantico Cemetery 4-9-2007 Quantico Va									
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Hypertensive atheros at dialysis procedure for er Due to (or as a consequence of):	sclerotic cardiovascu	ılar disease	complicating Between Onset and Death						
ecuted and - transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.									
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the buring.	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Frequent at time of death	etal death 3 Ectopic pregnother (Specify)	ancy	23d. Date of delivery Month Day Year						
P.O. E es that the igned by the detached	<u>آڅ</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown						
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Vital Regissician: The his certificate director, page	To Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatier	26.Place of Death (Check at 3 DOA Other Nursi		sidence 6 Other:						
ision of 'Attending Ph r death ector: After t by the funeral	Certification: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident Pending Investigation 28e. Place of Injury - At home farm str	1 Yes 2 No	28d. Describe how	injury occurred et and Number or Rural Route Number, City						
Divi Hospital or 24 hours afte Funeral Dir		Suicide Gould not be determined (Specify) 29a. Certifying Physician: To the best of my knowledge, death occur	urred at the time, date and place, and	or Town, State d due to the cause(s) and manner as stated.						
To the within. To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated 29b. Signature and title of certifier	ation, in my opinion, death occurred 29c. License number		d place, and due to the cause(s) 9d. Date signed (Month, Day, Year)						
Dag		Theodor M. King JA, Much,	O.C.M.E.		March 27, 2007						
		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimor	re, MD 21201							
St	ate	31 Date (iled (Month Cavitear) 32. Registrar's Signature									

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

			For	State	of Maryla	and / Depa				Mental Hy	giene			
			For State Registrar			Cei	tificate	of D	eath		Reg. No	07		941
· · · · · · · · · · · · · · · · · · ·	Physicia	an	1. Decedent's Name (First, Mid							2. Date of De Month	Day	Year	3. Time	
7	/Medic	al	Clara Virginia Th				4h City To		anation of Dan	3	26 20		8:35	A. M
	Examin	er	4a. Facility Name (If not institute 1644 St. Paul		umber)				.ocation of Dea	tn	4c. County			
- 146	Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	Hamps If Under 1	Year	If Under 24 Hrs	8. Date of Bi	Carr	9. Birth	place (State	or Foreign
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	pu >		Usual Residence of Decedent 10a. State 10b. Coun	tr	100	City, Town or Lo	cation						10d. Inside (City Limite
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	the N 28a-f notifie	rect	10e. Street and Number			ampo coac	10f. Zip C	Code			10g. Citizen of	What Cou		
	aa or	Funeral Director	1644 St. Paul	Street			2107				United			
	death	nera	11. Marital Status		cedent Ever in	n U.S. 13.	Vas Deceder	nt of Hist	panic Origin? (, Mexican, Pue	Specify Yes or No	o- 14. Rac	e - Americ	can Indian,	
ဖွ	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	/Fu	1 ☐ Never Married 2 ☐ Ma	arried 1 ☐ Yes	2 X No		ires, specily 1 □ Yes 2]		Specify:	nto nican, etc.)	Specif	ck, White,		
21215-0036	hours ural";	Completed by	3 XWidowed 4 □ Divorce	ed Year or I	Dates:							******		
15	n 72 n "nat edica	olete	(Specify only high	ent's Education hest grade completed		(Give	lent's Usual (kind of work DO NOT use	done du retired)	ion ring most of wo	orking	16b. Kind of B	Jsiness/In	dustry	
12	l withi jiene. r thar the M	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	Homen		,			Reside	nce		
þ	e filed al Hyg other rent,	BeC	17. Father's Name (First, Middl	e, Last)				1	18. Mother's Na	me (First, Middle	, Maiden Surnan	ne)		
Maryland	uld be Wents Irked Itic ev	일	Jabez Herbert	Martin					Lola	Marie Be	elt			
lar)	2 sho and I is ma		19a. Informant's Name/Relation				-				er, City or Town,			
	l and lealth im 27 her tr		Lena Ruhl - Da	ughter	201				Street	Hampste	ad, Mar			4
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation		State	b. Place of Dispo cemetery, crei ⊇isburq	natory or oth	er place)	3/2	9/2007	20c. Location - Parkton	•		a
鞋	it. Partmer		4 ☐ Donation 5 ☐ Other 21. Signature of Euneral Subject			_			1			-		
Ba	permi Depar Impor any ir	-	21. Signature of uneral state	The little	MO	01490 _{Ma}	in Str	reet.	El. Hamps	ine Fune tead Mar	eral Home	∍, 93 1074	4 Sou	th
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that	caused the deach line.	eath. Do not ent	er the mode of	of dying,	such as cardia	c or respiratory a	arrest,	073	Approxima Interval Bo	etween
Ş	Physician		Immediate Cause (Final disease or condition	. C	ONG	1-371	VE.	41	ART	FAL	LURE	-	Onset and	d Death
	/Medical Examiner		resulting in death)	Due to	(or as a cons	sequence of):		116	J. John Davidson					
2.4	Lxammer	_	Sequentially list conditions,	b. Free t	(or as a cons	was the con-						-		
	ted nsit	Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- Due to	(0) as a cons	sequence or,								
<u>,</u>	execunand and all-tra	Exar	that initiated events resulting in death) Last	c	o (or as a cons	sequence of):								
8760,	icate be executed physician and s the burial-transit	dical		d										
Φ	rtificat ng phy as th	Medi	IC FEMALE.											
Box	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou 1□Live	utcome pf pre birth 2 DF		Ectopic preg	gnancy				te of delive	-	Vasa
О	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time		Other (spec				Mic	onth	Day	Year
<u>G</u>	hat th d by 1 detach		Part II. Other significant condi	itions contributing to	death but not	resulting in the u	nderlying cau	ise dîven	in Part !	23e Did	tobacco use cont	ribute to t	he cause of	f death?
ds,	w requires that been signed to should be det	Completed by	CHRONIC	REN	AI_	EALL	LUR	1-	mr arr.		Yes 2∭X No	3 ☐ Prol]Unknown
200	v requ	etec	DEREGLE	POTI	E	ABT	HRI	7/	4	24a. Was				
Vital Records,	he lav e has ige 2:	E I	DEGENE	TALALI	101	TRI	1050	1 /	2,00	auto	psy ormed?	prior to co death?	opsy finding impletion of	cause of
ta			25. Was case referred to media	LNSUL	///	DEFER	XDEIX	(/	J / H/Q	ath (Check only	2 No	1 🗆 Yes	2 X No	
	Physician: r this certificanal director, I	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatien	t 3 □ DOA	Othor		1	idence 6 🗆 Oth	er (Speci	fv)	
٥	ding Phys 1. After this funeral di		27. Manner of Leath	28a. Date	e of Injury nth, Day Year	28b. Time of Injury	280	c. Injury a Work?			how injury occur		<i>y</i> /	
iğ	Attending r death. ector: After by the fune	atio	2 Accident	stigation	, 22, 7, 22.	/,,	M		es 2∐No					
Division or	or Att	Certification:	3 ☐ Suicide 6 ☐ Coul- 4 ☐ Homicide dete	rminod 200. Flac	e of injury - A ding, etc. <i>(Sp</i> e	t home, farm, str ec <i>ify)</i>	eet, factory, o	office		28f. Location (City or To	Street and Numb wn, State)	er or Run	al Route Nu	ımber,
	pital ours at eral C		29a. Certifier 1 Certify	ying Physician: To th	a heet of my	kanwledge deat	occurred at	t the time	date and place	o and due to the	pauso(s) and m			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only one)	ai Examiner: On the	basis of exam	nination and/or in	vestigation, in	n my opi	nion, death occ	curred at the time	, date and place,	and due t	o the cause	e(s)
	To the Vithin To the Complete	Me	29b. Signature and title of certif	fier 0		/	29c. L	License r	number		29d. Date signe	d (Month)	Day, Year)	
			Stode @ Z	TY X	7000	M.	リレ	2	505	2	3/2	7/0	200	7
	MSS		30. Name and address of person	on who completed cau	se of death (I	tem 23a) (Type,	Print)					211	17.	
			HAFEEZ	A SYE		20 Ct	2035)	ROA	DS]	RIVE	DWIN	331	MILL	5 MD
	Sta Registr		31. Date filed (Month, Day, Yea MAR 2		Registrar's Si	gnature	1			,				
	9.0		MAR A	· CUUI	WIRLIAM.	Kr L	32412 J							

Physician 1
/Medical =
Examiner
LAdillilei
and the same of th

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygient and Ental Hygient is it flem 21 is marked other than "natural", or items 23a or 28a-f show Important: it flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

To Be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi To the Hospital or Attending Physician: The law within 24 bours after death.

To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2.

Division or Vital Records, P.O. Box 68760,

Certification: To Be Completed by Physician/Medical Examiner

Medical

State

For		5	State of	f Mar	yland	l / Dep	partme	nt of H	lealth a	and M	1ental Hy	gien	е			
1 - State Registrar						Ce	ertifica	te of	Death			Reg. N	.20	07	ENGLAND CONTRACTOR	942
1. Decedent's Name	e (First, Middl	le, Last)									2. Date of De Month		ay	Year	3. Time	of Death
Mary Ag	nes Tu	rner									April	1	-	007	1:0	7 P.
4a. Facility Name (I			eet and nun	nber)			4b. City	, Town, o	r Location of	of Death		4	c. County			
St. Mar	y's Ho	spita	a1				L	eonar	dtown	1			St.	Mary	's	
Social Security N	lumber	6. Sex				st birthda		er 1 Year	If Under Hours	24 Hrs.	8. Date of Bir (Month, Da)ctober	th y, Year	7101	9. Birth	place (State	or Foreign
217-05-42		I L IV	1 2 X F		89	Yrs.				(ctober	13,	,1917	Mar	yland	
Usual Residence of 10a. State	Decedent 10b. County			1	0c. City.	Town or l	Location								10d. Inside	City Limits
Maryland	,	Mary	716		, ,		Mecha	nicer	7111a							s 2 No
10e. Street and Nur		riai j	, 5					ip Code	, 1116			10a C	itizen of V	What Cou		Λ.
							101.2	ip Code				rog. O	itizeli oi v	What Cou	iiitiy:	
28590 01	d Vill			doot Fu	or in II C	140	Was Das	206		ain? (Cn	ooifu Voo or No		JSA 14 Bac	o . Amori	ican Indian,	
11. Marital Status			Armed Fo	rces?		. 13	If Yes, sp	ecify Cub	an, Mexicai	n, Puerto	ecify Yes or No Rican, etc.)	,-		k, White,		
1 ☐ Never Marr 3 ☐ Widowed			1 ☐ Yes If Yes, Giv Year or Da	ates.			1 ☐ Yes	2 No	Specify:				Specify	Whi	.te	
	15. Deceder				\rightarrow	16a. Dec	edent's Us	ual Occup	pation			16b.	Kind of Bu			
	cify only highe	est grade c	ompleted)	4== = . \		(Git life	ve kind of w . DO NOT	ork done use retire	during mos d)	t of work	ing					
Elementary/Seco	indary (0-12)		College (1	-40r 5+)		Tele	phone	0per	ator			Te]	Lepho	ne C	ompan	у
17. Father's Name	(First, Middle,	Last)							18. Mothe	er's Nam	e (First, Middle	, Maide	n Surnan	ne)		
Richard	l J. Lo	ng. S	Sr						Mars	7 E.	Thomps	on				
19a. Informant's Na						19b. Ma	iling Addres	ss (Street			al Route Numb		or Town,	State, Zi	ip Code)	
William	L. Tur	ner J	Jr./So	on		1289	98 Jai	mesor	ı Driv	re I	Valdorf	, Md	1 20	602		
20a. Method of Disp	position				20b. Pla	ce of Dis	position (Na rematory or	ame of	00)		Date			City or T	own, State	
1 A Burial 2 4 Donation	□Cremation		noval from	State					1	A	11 / 20	07 N	f = 10 = 0		Moserr	l and
21. Signature J. Fu			1	1	St.	Jose	epn s 22. Name a	ceme and Addre	scery ess of Facili	Apr.	i1,4,20 ttingle	0 / I	TOLES	ınza,	Mary.	land
M	lecale	1	Sau	lin	ien.		P.O.B				ardtown			650	unera	I HOME
23a, Parni, Enter t	the disease, o	r complica	ons that c	aused th	ne death.									000	Approxim	ate
shock, or hea Immediate Cause	art failure. Lis	t only one	caus on e	ach line.	r						. ,			18	Interval B Onset and	etween 1 Death
disease or condition resulting in death)	on	a,_	71	00	·	" C	,tac	~~						-		
			Due to (H .	conseque	/ L	. 188	h								
Sequentially list co	nditions,	b	Duki to I	or as a	onseque	ence of):	n 910	••								
Sequentially list co cause. Enter Under Cause (Disease or	erlying -	<		D .	me		56									
that initiated events resulting in death)	5	C	Due to (1/	conseque		<i>/ - L</i>									
		t	,			,										
		d														
IF FEMALE:		230	. If yes, out	rome of	pregnan	CV							004 Da	4= =£ d=0;		
23b. Was deceden in the past 12	months?	200	1 ☐Live b	oirth 2	☐ Fetal of	death 3	B Ectopic		у			ĺ		te of deliventh	Day	Year
1 ☐ Yes 2 ☐ 9 ☐ Unknown	₽No		4□Pregn 9□Unkn		me or dea	atn :	5 ☐ Other (specity) _								
Part II. Other signi		ions contri	ibutina to de	eath but	not result	ting in the	underlying	cause div	en in Part l		23e. Did	tobaccc	use conf	tribute to	the cause o	f death?
, arm other eigh								3					2□ No	3□ Pro	4	Onknown
											24a. Was auto	psy	24b.	Were aut prior to co	topsy finding ompletion of	s available cause of
											perfo 1 Yes	ormed? 2 12 K	10	death? 1 🗌 Yes	2 No	
25. Was case referexaminer?	rred to medica									e of Deat	h (Check only	one)				
1 Yes 2 ₺	No	Hos	spital: 1 🚹	npatient		R/Outpat			4 🗆 111	ursing Ho	ome 5 Res	idence	6 □Oth	ner (Spec	cify)	
27. Manner of Deat		no	28a. Date (Mon	of Injury th, Day		28b. Time Injury		28c. Inju	ry at rk?		28d. Describe	how inj	ury occur	red		
1 ☑ Natural 2 ☐ Accident	5 □ Pendi invest	ng igation	1,	,,	- "	4-1	M		Yes 2□	No						

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manjo Panwala, 22576 MacArthur Blvd.

California, Md 20619

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2007

31. Date filed (Month, Day, Yea 2007

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of cert

6 ☐ Could not be determined



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 March 24. 9:50 PM June Mauvene Taylor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Kensington Nursing Home If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2**K** F 79 127-20-2539 9, 1927 Director New York Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director DC N/A Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1749 North Portal Drive, N.W. 20012 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married African 1 ☐ Yes 2 🗵 No Specify: Specify: Completed by 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Mathematician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie Gordon ဂ Wisner Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8103 Eastern Ave., #B509 Silver Spring, MD 20910 Erica Taylor Minor / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If it any Injury or conce, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery 4 ☐ Donation 5 ☐ Other (Specify) March 30, 2007 Washington, D.C. 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licenses 23a. Part 16 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7400 Georgia Ave., N.W. Washington, DC 20012 disease or condition resulting in death) Due to (or as a consequence of): DIABETIC Due to (or as a consequence of). NEPHROPATHY Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events DIABETES resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed

Physician /Medical Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

a or 28a-f show t be notified at

"natural", or items 23a o

the Medical

s 1 and 2 should be filed within f Health and Mental Hygiene.

Item 27 is marked other than "
other traumatic event, the Me

Pages 1

item 27 other to

The law requires that the death certificate be executed physician and s the burial-trans as Hospital or Attending

Division or Vital Records, P.O. Box 68760,

				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: Nursing	Home 5 ☐ Residence 6	□Other (Specify)
27. Manner of Death 1-☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, fact fy)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	ysician: To the best of my kno niner: On the basis of examina and manner stated.				and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier		2	29c. License number	29d Date	e signed (Month Day Year)

00057124

3128107

320,000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715 Medical Ctr. Dr.#201, Rockville, MD 20805 Truong Bao, M.D.

State Registrar 31. Date filed (Month, Day, Year) MAR 3 0 2007



nours after death.

neral Director: A
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within 24 To the

completely

			1 - For State Registrar	State of Maryla		artmeni rtificate			d Menta	l Hygien	211117	Brand Smill	14
	Physici /Medi		Decedent's Name (First, Middle, Las MYCHAL	JEROME T	URNER				2. Date Mor Mar	of Death th 27,	200 ^{Year}	3. Time of Dec	ath M
40	Examir	er	4a. Facility Name (If not institution, give 221-D S. Hampto 5. Social Security Number 6. Se	n Drive	rs. last birthday)		lver	Location of Do	.ng	F	c. County of Death		
198	Funeral Director		578-70-3740 11 Usual Residence of Decedent	DXM 2□ F 5	4 Yrs.	Months	Days		lin. Dec	of Birth oth, Day, Yea 21, 1	952 Was	lace (State or Fo	reign
	he Marylar Be-f ehow	ector		Georges	City, Town or Lo	er S		ıg				0d. Inside City L	
	h with ti	al Dire	10e. Street and Number 221-D S. Hampto	n Drive		10f. Zip	Code 0903			10g. C	U.S.A.	ntry?	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 ie marked other than "natural", or itams 23e or 28e-f show any njury or other traumatic event, the Medical Evantina roual be notified at an a.	d by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1X Yes 2 No If Yes, Give 978 Year or Dates: 198	3 to	Was Deced f Yes, spec		spanic Origin? , Mexican, Pu Specify:	(Specify Yes Jerto Rican, e	or No- tc.)	14. Race - Americ Black, White, Specify: Bla	etc.	
Maryland 21215-0036	d within 72 h giene. or than "natu the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12) 12	ucation	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us Bake:	k done di e retired)	tion uring most of	working		Kind of Business/Ind	,	
yland	ould be file Mental Hyg Marked othe	To Be C	17. Father's Name (First, Middle, Last) Joseph H. G					18. Mother's I	Gera	Middle, Maide ldine	n Sumame) Turn	er	
	and 2 sh alth and 27 le rr		19a. Informant's Name/Relationship (T. Geraldine T. Jo								or Town, State, Zip pring, M		3
Baltimore,	Pages 1 ament of He ent: if item lury or oth		20a. Method of Disposition	Removal from State	. Place of Dispo cemetery, cren ID. Vete	natory or ot	her place		Date r.4,0		Location · City or To eltenhan		
Ba	Depart Import		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp	Hunt	H		Tun.	Home			y St.N.	2001] W.Wash.	DC
8760,	The law requires that the death certificate be executed It has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Jicai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute (Due to (or as a consi Due to (or as a consi Due to (or as a consi Due to (or as a consi Due to (or as a consi	equence of): ial In equence of):				ncy			Interval Between	
P.O. Box 6	w requires that the death certifical been signed by the attending plandould be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 □	Ectopic pre				_	23d. Date of delive Month	ry Day Year	
rds, P	quires that an signed b	by	Part II. Dther significant conditions co	ntributing to death but not r	esulting in the ur	nderlying ca	use giver	n in Part I.	23e	. Did tobacco	use contribute to the	e cause of death	
Division of Vital Records,	iician: The law re certificete has bee rector, page 2 sho	Completed		-					-	Was an autopsy performed?	prior to cor death?	osy findings avail npletion of cause 2 \(\text{No} \)	able of
Į Ķ	Physician this certif al directo	To Be	25. Was case referred to medical examiner? 1★ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatien	3 DO	Otho	26. Place of □			6 ☐Other (Specify	·)	
sion o	Attending Physician: r death. setor: After this certifice by the funeral director, is	ation:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	3c. Injury a Work? 1 □ Ye			cribe how inju		,	
DIX	i git o	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	cify)				City	or Town, Stai			
	To the Hospital within 24 hours and to the Funeral completely filled	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exemi	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred a estigation,	it the time in my opii	, date and pla nion, death oc	ce, and due to curred at the	to the cause(s time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)	
)	withi To th	Σ	29b. Signature and title of certifier	teRolle	.m.S	29c.	D00	number 07967			ch 29,2		
4	3)/4		30. Name and address of person who can Albert E.Rolle,	M.D. 600 R	iverbe	nd R	oad	Fort	Washi	ngton	,MD.207	4 4	
\$ 18. *** ***	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 2007	32. Registrar's Sig	nature	,							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 27 2007 1325 Robert Joseph Updike March /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Carroll Hospital Center Westminster Carroll 8. Date of Birth (Month, Day, Year) If Under 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □**X**M 2 □ F Hours Yrs. 468-62-8079 Director Sept 2 1951 Germany Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 23a or 28a-f show Ħ 1 □ Yes 2 □ No be notified Director MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 21157 3340 Sykesville Road USA Funeral "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 10 1 ☐ Yes 2 ☐ No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. the 12 Telephone Tech Fortran Corp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file treent of Health and Mental Hy tant: If item 27 is marked oth Be Marie Preshing Martin Updike ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Updike/wife 3340 Sykesville Road Westminster, MD21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or c 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 3/28/2007 4 □ Donation 5 □ Other (Specify) Carroll Cremation; Hampstead, MD Inc 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 412 Washington Rd Westminster. MD21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Concer **Physician** State 14Rev /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 ™hknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ₩6 autopsy certificate 2∐**1**No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No 1 Inpatient ို 2 ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 TYes 2 TNo investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

P.O. I Records. Division or Vital Hospital or Attending Physician: Justification .
4 hours after deau.

-ral Director: A'

- by the 24 hours a within 2.

To the f

Baltimore, Maryland 21215-0036

Box 68760.

MJL

DHMH 17 Rev 1/2001

State Registrar (Check only one)

29b. Signature and title of certifier

Stmer 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 5203C

29d. Date signed (Month, Day, Year)

Westminster MD 2/157

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	State of	of Maryla	nd / De	nartment	of He	alth and	Mental F	-lygiene	201	

			1 - For State Registrar		f Marylar	-	artment of F		Mental Hy	giene Reg. No.		113	40
	Physici /Medi		1. Decedent's Name (First, Middle, L Alvin K.	upton, S	r.				2. Date of De Month March	26,	2007	3. Time of De 4:00	ath AM
72	Examir	ner	4a. Facility Name (If not institution, g Cherry Lane Nur	sing Hom			Laure1	r Location of Deatl	1		nce Ge		
	Funeral Director		5. Social Security Number 6. 414-28-0743 Usual Residence of Decedent	Sex 1X M 2□F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month Da 8-3-19	th 26	Cor	pplace (State or Fo intry) Etwater,	_
	death with the Maryland ma 23s or 28s-1 show rmat be notified at	Director	10a. State 10b. County MD Prince (10e. Street and Number		10c. Ci	ty, Town or Lo	10f. Zip Code			10g. Citize	en of What Cou	10d. Inside City L 1 Yes 2	_
21213-0036	be filed within 72 hours after death with the Marylan hat Hygiene of other than "natural", or itema 23s or 28s-1 show event, the Madical Examiner must be notified at	by Funeral	14707 Danton Coun 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest of	12. Was Dece Armed Fo 1 Z Yes If Yes, Gin Year or D	2 No 19	45 45	20721 Was Decedent of H f Yes, specify Cuba I Yes 2 X No	Specify:	o Rican, etc.)	5	ted Sta 4. Race - Amer Black, White Specify: Bla d of Business/li	ican Indian, , etc. .ck	
	filed within 7 ! Hygiene. other than "r	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La:	College (1 5+	1-4or 5+)	Princ	kind of work done of NOT use retired	18. Mother's Nar			ation		
ryland	2 should be and Mental Is marked o	ToB	Eli Mayotte	(Type Print)		19h Mailir	g Address (Street	Helen Up		var City or	Tour State 7	in Code)	
тоге, ма	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ex		Sharon Calvin (20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	daughter	State 20b. F	14707 Place of Dispo	Danton Sition (Name of natory or other place acoln Cem	Court B	owie, <u>M</u> Date	2072 20c. Loc	21 ation - City or T	own, State	
Daitimor	permit. Departm Imports any inju		21. Signature of Funeral Service Lic		e-e-	22	Name and Address	ss of Facility Fo:	rt Linco	oln Fu	ıneral	lome	
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colds, r	equires that en signed b ould be deta	by	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the ur	nderlying cause give	en in Part I.		obacco us		the cause of death	
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Ē	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying F	hysician: To the	ng, etc. (Specif	y) wledge, death	occurred at the tim	ne, date and place	City or Ton	wn, State)	nd manner as	stated	
,	To the Hi within 24 To the Fi	Medical	29b. Signature and title of certifier 29b. Name and address of person who Andres Salazan	A Manage of the base of the ba	asis of examina her stated.	1 D n 23a) (Type,	29c. License	number	rred at the time,	29d. Date	signed (Month,	Day, Year)	
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DHMH 17 Rev 1/2001

		1 = For State Registrar	State of Maryland		rtment of Hetificate of L			iene () ()	7 11947		
Physici /Medic		Decedent's Name (First, Middle, Last) GRADY VINI	ES				2. Date of Dea Month MARCH	Day	3. Time of Death 11:20P м		
Examir		4a. Facility Name (If not institution, give str. 4005 AYDEN COUR! 5. Social Security Number 6. Sex		hirthday	4b. City, Town, or MITCHEI If Under 1 Year		8. Date of Birth	4c. County o	NCE GEORGES		
Funeral Director			4 2□ F 64	Yrs.	Months Days	Hours Min.	05/06/	Year)	9. Birthplace (State or Foreigr NASHVILLE, NO		
Maryland f ehow	or	10a. State 10b. County	10c. City, T		ation	TD			10d. Inside City Limits		
h with the ? 23a or 28a-	al Director	MD PRINCE (10e. Street and Number 4005 AYDEN COUL		MITC	101. Zip Code 20721		1	0g. Citizen of W			
urs after deal at', or tteme : Examiner mu	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1Yes _ 2\(\) No If Yes, Give Year or Dates:	If	/as Decedent of His Yes, specify Cubar ☐ Yes 2 XNo	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or items 23s or 28s-f show any fulury or other traumatic event, ira Medical Examinar must be notified at ance.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 9 TH	tion 1. completed) College (1-4or 5+)	(Give k	ent's Usual Decupa ind of work done di O NOT use retired) CHEF	uring most of work	ng		b. Kind of Business/Industry		
ild be filed lental Hyg ked other	To Be C	17. Father's Name (First, Middle, Last) MARK VINES		-		18. Mother's Name	(First, Middle, I		1)		
and 2 shou eith and M 27 ie mar er traumai		19a. Informant's Name/Relationship (Type BARBARA VINES/		9b. Mailing	Address (Street a	nd Number or Rura	al Route Number CHELLVI	City or Town, S LLE , MD	State, Zip Code) 20721		
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cate be executed physician and the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):							
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To t Com	Σ	29b. Signature and title of certifier			29c. License		29		(Month, Day, Year)		
(3)		30. Name and address of person who comp	ted cause of death (Item 23a		mD2.		F WDC	20002	28, 2007		
Sta Registr		EDSEL AYOSO 31. Date filed (Month, Day, Year) APR 02 2007	32. Registrar's Signatura		C211 1 1 0.		,		-		
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Gloria Annice Vandevere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2007

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State of Maryland / Department of Health and Mental Hygiene

	_		1- For State Registrar		Certific	ate of	Death		, 0	Reg. No	2		
	Physici		1. Decedent's Name (First, Middle,I	_ast)					2. Date of De Month	eath			3. Time of Death
Medica	ıl Exam	inei	GIOTI	a A.		Vande			April 6, 2	2007 2007	Year		1739 hrs
			4a. Facility Name (if not institution, Union Hospital	give street and number)		4	b. City, Town, o	or Location of	Death		lc. County of Cecil	Death	
	uneral			Sex 7. Age	e (In yrs. last bir	thday)	If Under 1 Ye	ar If Under	24Hrs. 8. Date of I			O Diah	alone (Otata
	irector		i i			- 7	Months Da	_	Min		ſ	Foreign	place (State or Mary land
			Usual Residence of Decedent	M 2 F 5	51	Yrs.	<u> </u>		NOV 7	, 1	955	Cour	ntry)
	any		10a. State 10b. County		10c. City, Town	or Location	on			_		1	0d. Inside City Limits
	show	_	Maryland Cecil		E1kt	on							1 X Yes 2 No
-	Aaryla 28a-f l at oi	Director	10e. Street and Number		LIKE		10f. Zip Code			10g. Ci	tizen of Wha	t Countr	y?
	a the r	흅	120 East Stock	cton Street			2192	21			United	l S±	ates
	red winn 12 nours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S		Decedent of H	ispanic Drigir	n? (Specify Yes or N Puerto Rican, etc.)		14. Race -	America	n Indian, Black,
	or it	핊	1 Never Married 2 X Marri	1 Yes 2	X No				ruerto Rican, etc.)		White,	etc.	
d	rs affe	ğ	Widowed 4 Divorce 15. Decedent's Education (Specify)	ced If Yes, Give Year or Dates:	alatad) IdGa		Yes 2 X N			1.2		Whi	
	"nat	eted	Elementary/Secondary (0-12)	College (1-4 or 5		during mo	st of working life	e. DD NOT u	nd of work done se retired)	166.	Kind of Busi	ness/Inc	lustry
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121	ental l erked urked vent,	Be	Harold E. Rice					Mar	y M. Baby	1on			
0.2	nd M is ma	70	19a. Informant's Name/Relationship					et and Numb	er or Rural Route N	umber, C	City or Town,		
MD.	Health and Nitem 27 is n		Gregory L. Var	idevere/Hust		120 E	ast Sto	ckton	Street, I	1kt	on, Ma	ry1	and 21921
Baltimore,	rages - and 2 should be fried whinh 72 hours after death with the Maryland mort of Helain 217 and should bygene nant: If item 217 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		1 X Burial 2 Cremation	3 Removal from Stat	te Ci Ini	ory or othe	on (Name of Ce er place)	emetery,	April 11,	20c.	Location - C	ity or To	own, State
ti.	tment rtant:		4 Donation 5 Other Spec		Gilpi Memor	ial P	ark	2	2007	E1	kton,	Mar	yland
Bal	Department of H Important: If i		22. Name and Address of Facility Hicks Home for Funerals P.A.										
	/sician		23a. Part I. Enter the disease, or cor	mplications that caused t	he death. Do no	1103 ot enter the	W. Sto	ckton such as can	Street, I	1kt	on, Ma	ryla	and 21921 Approximate Interval
/N	ledical		failure. List only one cause on	each line. a. Complication									Between Onset and Death
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4	=	хаш	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):								
	and trans			d									
Sion of Vital Records, P.O. Box 68760,	physician and the burial - transit	n/Medical	X UNPENDED	AMENDED 27,28	a-f, perM	Æ, g86	56, 4/17/	07 TT					
8760,	g phy	ğ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	e or pregnancy					23	d. Date of de		
39 ×	endin use a	cial	past 12 months?	4 Pregnant at ti			Ideath 3 or (Specify)	Ectopic p	pregnancy	.00	Month	Day	Year
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i o	n. After t funeral	ᇹ	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Yea	y 28b. ⁻ ar)	Time of Inj	· '	iry at Work?	28d. Describe	how inj	ury occurred		
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	2 t =	Certifi	3 Suicide 6 X Could no determin					ouilding, etc.	28f. Location or Town, 120 E. S	(Street a State)	and Number	or Rural	Route Number, City
]	t hour unera		29a. Certifier	(Checkity) IOI	und in re			ote and place					on, MD
Div To the Hospital or	within 24 hours a To the Funeral I completely filled	edical		ician: To the best of my ler:On the basis of exami									ause(s)
Ę	To COU	Mec	29b. Signature and title of certifier	and manner stated.			29c. Licens	se number		29d.	Date signed	(Month	. Day, Year)
			(ayde	HALLO	010		O.C.	M.E.		Apr	il 7, 2007		
			30. Name and address of person who	completed cause of de	ath (Item 23a)						-		
	•			tant Medical Exami	iner 111	Penn St	reet, Baltim	ore, MD 2	1201				
	St	ate	31. Date filed (Month, Day Year)	2007 32. Registrar's	Signature	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

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4	-		Registrar 1. Decedent's Name (First, Middle, Las	t)		061	inicale of	Deal	,,	2. Date of De				3. Time of Death
	Physici /Medic		Nancy	E.	Wendel	(Month O4	03		ar 🕝	1548 M
	Examir		4a. Facility Name (If n		street and number)			4b. City, Town, o	or Locatio	n of Death		4c.	County of D	-	
	**************************************		Coastal Ho: 5. Social Security Num	spice at		e (In yrs. last	t hirthday)	Jalish If Under 1 Year	U / V	er 24 Hrs.	8. Date of Bi	1	licomi		(Otata Fa
6,	Funeral Director		231-36-961	.3	□M 2ME	8	Yrs.	Months Days	Hours	s I Min. I	(Month, Di	ay, Year)		Country Tgi	nce (State or Foreign y) nia
	and w		Usual Residence of De 10a. State 1	ecedent 0b. County		10c. City, T	own or Lo	cation						100	d. Inside City Limits
	Maryl i-f sho fied a	tor	MD W	icomico		Salis	hurv								1 □Yes 2 X No
	or 288 e noti	Director	10e. Street and Numb				July	10f. Zip Code				10g. Citi	izen of What	Countr	y?
	ath wi		1519 Wood1	and Roa				21801				USA	<u> </u>		
36	172 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4		12. Was Decedent I Armed Forces? 1 Yes 2 In If If Yes, Give Year or Dates:			Vas Decedent of I f Yes, specify Cub □ Yes 2 No	Hispanic (ean, Mexic Speci		cify Yes or No Rican, etc.)	0-	14. Race - A Black, W Specify:	hite, et	c.
215-0036	72 hou natura ical E	ted	(Specific	5. Decedent's Ed	ucation	1	I6a. Deced	lent's Usual Occu	pation	*** **********		16b. Ki	ind of Busine	ss/Indu	stry
21	d within 72 ho giene. r than "natu the Medical	Completed	Elementary/Second		College (1-4or 5			kind of work done OO NOT use retire		ost of workir	ng	pict	ure f	rami	ing busines
d 21	e filed wall Hygie other t		17. Father's Name (Fil	rst, Middle, Last)	4	1	DUSTI	ess owne	Т	ther's Name	(First, Middle	e, Maiden	Surname)		
Maryland	o o o	ro Be	Joseph Ph	illip E	ubank						rison		•		
lary	2 should and Men is marke aumatic		19a. Informant's Nam	, ,				g Address (Street						e, Zip C	(ode)
	s 1 and 2 of Health a item 27 is other trai		Harold J. 20a. Method of Dispos		L,Jr so			Redden F			Eden,				-
nor	Pages nent of h nt; If ite		1 ☐ Burial 2 🛣	remation 3 🗆	Removal from State			sition (Name of natory or other pla					cation - City		
altimore,	+ # 5 = -		4 □ Donation 5 21. Signature in Fune		19.00	cape	1 22	les Ceme Name and Addre	ass of Fac	sility			char.	les,	Virginia
ä	permi Depa Impo any Ir once.		Hu	110	night	y		ilkins-D 19 Pine	Stre	et, Ca	ipe Cha	irles	, VA 2	2331	.0
	4			allure. List only o	lications that caused one cause on each lir	the death. D	Do not ente	er the mode of dyi	ng, such	as cardiac o	r respiratory a	arrest,		Į.	Approximate nterval Between Onset and Death
	Physician /Medical		Immariate Cause (Fir disease or condition resulting in death)	nal	a. Metast	atie	Ble	elden	(anc	u				And the Death
	Examiner				Due to (or as	a consequen	ce or):								
	D .=	ner	Sequentially list condi- il any leading to inno- cause. Enter Underlyi	ediata ing	Exus to (or as a	в сопъзсиен	ne digr								
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68760,	rificate be executed g physician and as the burial-transit		,		Due to (or as a	a consequen	ce oi).								
687	ifficate g phys	edical			d										
Box	death certi e attending id for use a	an/M	IF FEMALE: 23b. Was decedent pr	egnani	23c. If yes, outcome 1 ☐Live birth			Ectopic pregnanc	v			2	23d. Date of		
	res that the death certiligned by the attending be detached for use a	Physician/M	in the past 12 mc 1 ☐ Yes 2 6 N 9 ☐ Unknown	onths? No	4□Pregnant at 9□Unknown			Other (specify) _					Month	D	ay Year
, P.O.	that the led by detac		Part II. Other significa	ant conditions co	ntributing to death bu	ut not resultin	g in the un	derlying cause giv	/en in Par	t I.	23e. Did	tobacco u	ise contribute	to the	cause of death?
or Vital Records,	law requires that the as been signed by th 2 should be detache	ed by									1 🗆	Yes 2	X lo 3□	Probab	oly 4 ∐Unknown
ecc	e law re has ber je 2 shc	Completed									24a. Was		24b. Were	autops	sy findings available pletion of cause of
a B	F age ☐										perfo 1□ Yes	ormed? 2 No	death 1 🔲 Y	? '	□ No
ξ	siciar certif irector	Be	25. Was case referred examiner?	-	Hospital:	0000	/O	Oth	er.		(Check only o				
יסר	g Phys ter this neral dii	n: To	27. Manner Death		28a. Date of Injur	ry 28	b. Time of	28c. Inju	4 □ □		ne 5 🗌 Resi 8d. Describe			pecify)	
sior	Attending Physician: r death. ector. After this certific. by the funeral director,	atio	2 ☐ Accident	5 Pending investigation	(Month, Day	(rear)	Injury		Yes 2	□No					
	l or Att after de Direct I in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of inju building, etc	rry - At home c. (Specify)	, farm, stre	et, factory, office		2	8f. Location (City or To	Street and wn, State	d Number or)	Rural F	Route Number,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral.		29a. Certifier (Check only 2	Certifying Phy	sician: To the best of iner: On the basis of	of my knowled	dge, death	occurred at the ti	me, date	and place, a	and due to the	cause(s)	and manner	as stat	ed.
	o the lithin 2, o the l	Medical	one) 29b. Signature and title		and manner sta	ited.		29c. Licens			- J at the time,		e signed (Mo		<u></u>
	F 3 F 8	-		75 /	W W	WS		1/2	/ 5	78		4 -	. 4	3 7	y, rear/
	7	-	30 Name and address	s of person who c	ompleted cause of de	eath (Item 23	a) (Type, F	Print)	61	-/0		- (1 - 6	/	
	5		David E.	Court 1	1) Cast	1/40581	ie /		1733	S	alish	m	D 21	902	participan .
	Sta Registr		31. Date filed (Month,	Day, Year) 7 R 1 3 200		ar's Signature	Good	le le)/				

Division or Vital Records, P.O. Box 68760,

		Please Type or Print State of Ma 1- For State Registrar	ryland / Depa		lealth and	-		egible.	1195/
Physici /Medio		1. Decedent's Name (First, Middle, Last) Constance L. Welsh				2. Date of De Month		2007	3. Time of Death 7:13 P. M
Examin Funeral Director		219-44-8352 1□M 2XIF	(In yrs. last birthday) Yrs.	4b. City, Town, of Towson If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 9/7/19	rth		
the Maryland 28a-f show notified at	Director		10c. City, Town or Lo	cation 10f. Zip Code			10g, Citiz		10d. Inside City Limits 1 Yes No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: I fire Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral D	3603 Carrollton Road 11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	21155 Was Decedent of Hif Yes, specify Cub 1 □ Yes ※☐ No dent's Usual Occup kind of work done DO NOT use retire	Specify: pation during most of wo		0- 1	4. Race - Ameri Black, White Specify: Whi	can Indian, , etc. te
uld be filed within whental Hygiene. Irked other thar than the Martic event, the Martic event, the Martic event.	To Be Comp	Elementary/Secondary (0-12) College (1-4or 5+ 12 17. Father's Name (First, Middle, Last) William Paul Schaper	Packe		18. Mother's Nar	,	, Maiden	ook Mfg. Surname)	
es 1 and 2 sho of Health and I fitem 27 is ma		19a. Informant's Name/Relationship (Type. Print) Edward W. Welsh, Sr Husk 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	pand 3603 20b. Place of Dispo		on Road (Jpperco,	Mary 20c. Loc	rland 21 cation - City or T	155 Town, State
permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Evergreen Moo1490	2. Name and Addre)/2007 Line Fun	eral	Home. 9	Maryland 34 South
Physician /Medical Examiner	lan.		9.	er the mode of dyli					Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit	lical Examiner	Cause (Disease or injury that initiated events c.	consequence of):						
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	P ☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify)	1		2	3d. Date of deliv	very Day Year
w requires that been signed b	Ď	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.				the cause of death?
in; The law ificate has b or, page 2 st	Completed	25. Was case referred to medical			26. Place of Dea	1□ Yes	ormed? 2 No	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Mospital: 1 Inpatien 28a. Date of Injury (Month, Day) 2 Accident investigation	Year) 28b. Time of Injury	f 28c. Injul Wor M 1 🗆	er: 4 Nursing F	flome 5 Res 28d. Describe	idence 6 how injury	occurred Number or Rur	ral Route Number,
he Hospital n 24 hours a he Funeral pletely filled	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of and manner state.	examination and/or in	n occurred at the tivestigation, in my o	me, date and place	e, and due to the urred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
Mithi Vom	Ž	29b. Signature and title of certified			e number 58303			e signed (Month,	
Sta Registr	ar	30. Name and address of person who completed cause of dea Armon J. C. W. W. W. W. M. M. M. M. M. M. M. M. M. M. M. M. M.	6701 N.	Montes	ST TOWSO	M M	2120	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>007</u> March 29, WALTER LEROY WINEBARGER 9:25 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center La Plata Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 29, 1933 9. Birthplace (State or Foreign Country) Virginia 6. Sex 7. Age (In yrs. last birthday) Min. Months Days Hours 1 X M 2 □ F 73 229-38-4529 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No St. Mary's Charlotte Hall Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 37606 Handel Drive 20622 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☒ No Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck/Auto Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Quinton Winebarger Dora Edith Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolee M. Winebarger - Wife 37606 Handel Drive, Charlotte Hall, MD 20622 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Trinity Memorial Gdns 4-2-07 Waldorf, MD 4 Donation 5 Dother (Specify) 21. Signation of Funeral Service Licenses 22. Name and Address of Facility M00053 3035 Old Washington Road **Huntt Funeral Home** Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinima Due to (or as a consequence of): Due to (ords a consequence of) Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of

Physician /Medical Examiner

physician and is the burial-trans

Physician

Examiner

Funeral

Director

r 28a-f show notified at

with a or

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must bonce.

Baltimore, Maryland 21215-0036

/Medical

Director

by Funeral

Completed

Be

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	L.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2			pregnancy (specify)			23d. Date of delivery Month Day Yea	r
		tributing to death but not resulting in the und	, ,			23e. Did tobacc	o use contribute to the cause of deat	h?
Chonic obs	Fr	active pelmonary	d	المحدي		1 ☐ Yes	2 No 3 Probably 4 Unk	now
Dabetes m Hypertensi	cl	litus				24a. Was an autopsy performed′		
25. Was case referred to medical				26. Place of De	ath (C	heck only one)		
examiner? 1 ☐ Yes 2 ☐ No	F	lospital: 1 ☑Inpatient 2 ☐ ER/Outpatient	3 🗆 [DOA Other: 4 Nursing	Home	5 Residence	6 ☐Other (Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		28a. Date of Injury (Month, Day Year) 28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d	. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		28e. Place of injury - At home, farm, streen building, etc. (Specify)	et, facto	ory, office	28f.	Location (Street City or Town, St	and Number or Rural Route Number ate)	;
29a. Certifier 1 ☐ Certifying (Check only one)	Phys	sician: To the best of my knowledge, death ner: On the basis of examination and/or invi- and manner stated.	occurre estigati	ed at the time, date and place on, in my opinion, death occ	ce, and	due to the cause at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)	
29b. Signature and title of certifier			2	29c. License number		29d. [Date signed (Month, Day, Year)	

P53552

03/30107

DHMH 17 Rev 1/2001

State

Registrar

after death.

| Director: /

within 24 hours aft

To the Funeral Di

completely filled in

CASTREME, Old Line Center, Waldorf, MD 20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

MAR 3 0

32. gistrar's Signature

am	end ite	m	1- For State Registrar#19a, per F.I	State of Mary	land / Depa	artment of H			E U U I	11952
alli	lend ite	111	1. Decedent's Name (First, Middle, Last)	,07	Timodio or E	Joann	2. Date of Death		3. Time of Death
П	Physici /Medio		Mildred I. Wi	ddowson				Month March	27, 2007	4:50PM M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death	1.50211
	3 4 1	9	Alice B. Tawes Nu	rsing Home		Crisfie			Somerse	
	Funeral		5. Social Security Number 6. Se	TM 2XF	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		215-20-2159 Usual Residence of Decedent	87	TIS.			12/23/	1919 Mary	land
	/land		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar.	tor	MD Somerset		Crisfi	e1d				1 XÎYes 2 □ No
	th the	Director	10e. Street and Number		011011	10f. Zip Code		10	g. Citizen of What Cou	ntry?
	23a	ral	201 Hall Highway				21817		USA	
	er de	Funeral	11. Marital Status	Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cubai	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	rs aft	by F	1 Never Married 2 Married 3 Nover Married 2 Married 3 Nover Married 2 Noverced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	• •
8	72 hours after death with the Maryland natural', or iteme 23a or 28e-f ehow dical Examiner mart by incilled at		15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation		6b. Kind of Business/Ir	iite
215	hin 72	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	luring most of works	ng		
21	ad with	Com	11	none	Cle	rk			Acme Mar	kets
nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	laiden Sumame)	
yla	ould Men Marks Marks	ို	Fred H. Johnson				Maggie F			
Maryland 21215-0036	12 sh h and 7 is m		19a. Informant's Name/Relationship (T) Myrna Widdowson			-			City or Town, State, Zij	
	1 and Healt em 2 thar i		20a. Method of Disposition		0b. Place of Dispo				S Anne, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-f ehow any injury or other traumatic event, the Marical Examiner must be notified at ance.		1 Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	cemetery, crei	natory or other place	9)	-		
Itiu	artme ortan injury	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens			ews Episc Name and Addres		1/200/	Princess An	ine, MD
Ba	Dep imp	8	MODE OVINN	aix h	Н	inman Fun	eral Home			
	8 8		23a. Part1. Enter the disease, or compl	M002 ications that caused the		1673 Som er the mode of dying	l erset Ave g, such as cardiac o	r respiratory arre	cess Anne,	Approximate
300	Physician		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	*	1000				Interval Between Onset and Death
3	/Medical		disease or condition resulting in death)	Due to (or as a cor		SCVD				
	Examiner		Conventielle, liet conditions	D						
	ם ב	ner	Sequentially list conditions, and say say in the say is a cause. Enter Underlying Cause (Disease or injury	Due to (or es sigor	nsequence of)					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
8760,	ate be executed hysician and the burial-transit	cal E	1999 III asalii ji East	Due to (or as a cor	rsequence of):					
387	icate be executed physician and s the burial-transit	77		d.						
9 x	certif ding se a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pro	egnancy				23d. Date of delive	on.
Вох	that the death ned by the atter detached for u	clar	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time		Ectopic pregnancy Other (specify)			Month Month	Day Year
P.O.	t the di by the ached	hys	9 Unknown	9□ Unknown						
	w requires that s been signed t should be deta	by P	Part II. Other significant conditions con	ntributing to death but not	t resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
ğ	en sig	ed						1 ☐ Yes	s 2 No 3 Prot	oably 4 □Unknown
ecc	as be 2 sho	Completed						24a. Was an		ppsy findings available
Œ	rician: The tav certificate has rector, page 2	Com						autopsy perform		mpletion of cause of 2[] No
/ita	cian: ertific actor,	Be (25. Was case referred to medical examiner?				26. Place of Death			
7	Physic this o	၉	1 □ Yes > No		2 ER/Outpatier		4V Nursing Hon	ne 5 🗆 Resider	nce 6 Other (Specia	(y)
n C	Attending Physician: sr death. ector: After this certifics by the funeral director. I	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury Work		28d. Describe how	v injury occurred	
isi	ttend death stor: ,	cat	2 Accident investigation 3 Suicide 6 Could not be	Ole Blees of Injury	At home feet the		res 2 □ No	206 1 101		
Division of Vital Records,	i or Attendater deatl Director:	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	pecify)	eet, factory, office		City or Town,	eet and Number or Rura State)	al Houle Number,
	To the Hospital or Attending Physician: The within 24 burs after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 X Certifying Phys	sician: To the best of my	knowledge, deatl	occurred at the time	e, date and place, a	and due to the car	ise(s) and manner as s	tated
	P Fu	edical	(Check only 2 Medical Examinate)	ner: On the basis of exame and manner stated.	mination and/or in	estigation, in my op	inion, death occurre	ed at the time, da	te and place, and due to	the cause(s)
	To the Hospital within 24 hours a To the Funaral Completely filled	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month,	Day, Year)
				19		D	48098		3/28/20	707
			30. Name and the ress of person who co	mpleted cause of death	(Item 23a) (Type,	Print)	A 1 . 1/15	W.OV /		
	6		V /	ARVMBUNI		201 H	ALL HIG	mw1+7, (PRISFIELD	,14(1) 2101/
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 2	32. Registrar's S	ignature	1				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend ### Pet Many legit before the partners of P

			Registrar		Certific	ate of L	Death			R	eg. No.	
Medic	Physici cal Exam		Decedent's Name (First, Middle,La	Vincent Ty	rone V	vood1a	and		2	2. Date of Dea Month March 25 ,	Day Yea	3. Time of Death 0537 hrs
			4a. Facility Name (if not institution, g I-495 @ Arena Drive	give street and number)			. City, Town, Larg o	, or Location of	of Death		4c. County of Prince G	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last bir	thday)	If Under 1 Y		er 24Hrs.	8. Date of Bir	th(MM/DD/YYYY	9. Birthplace (State or Foreign
	Director		214-72-4 130	X M 2 F	49	Yrs.	Months D	Days Hours	Min.	Oct 12	2, 1957	Country)Wash DC
	any		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town	or Location	1					10d. Inside City Limits
		or	Maryland Prince	George's			Lanh	am				1 XYes 2 No
	ages I and 2 should be filed within 72 hours after death with the Maryland angles I and 2 should be filed within 72 hours after death with the Maryland into Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Director	7319 Oliver Stre	eet			10f. Zip Code	20706		1	0g. Citizen of Wh	nat Country? SA
	death with or items 2.	Funeral	11. Marital Status 1 Never Married 2 Marrie	1 X Yes 2	No			Hispanic Orig ban, Mexican,		cify Yes or No ican, etc.)	- 14. Race White	- American Indian, Black, e, etc.
	s after rral", o	ò		ed If Yes, Give Year 1976 or Dates:				No specify:			Specify:	Black
	2 hour "natu	eted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)		Decedent's during mos	Usual Occu t of working	pation (Give life. DO NOT	kind of wor use retired	rk done d)	16b. Kind of Bu	siness/Industry
036	within 7 iene. Ier than	ompleted	12th			Secu	rity (Guard			Gove:	rnment
0-5	filed w Hygic d othe	ပ	17. Father's Name (First, Middle, Las	·				18.Mother	,		Maiden Surname)	
21215-0036	uld be filed vineral Hygimarked oth	To Be	Raphael Vincer 19a. Informant's Name/Relationship		19	b. Mailing A	ddress (St	reet and Num		a Jacks		n, State, Zip Code)
Z	12 shooth and 127 is umatic		Angela Woodland	(Wife)								Hgts, MD 20747
e de	permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	20b. Place of		on (Name of			Date	20c. Location -	City or Town, State
Baltimore	교 의 등 교		4 Donation 5 Other Specif	fy:	4	teran	's Cen	netery	_4/2	2/2007	Chelte	enham, MD
<u> </u>	permit. Departir Imports injury o		21. Signature of Funeral Service Lice	Services, P.A.								
	hysician		23a. Part I. Enter the disease, or con failure. List only one cause on a		e death. Do no						ham, MD est, shock, or hea	
	/Medical xaminer			A. Multiple Injuries Due to (or as a consequ	ence of):							Death
			Sequentially list conditions,	b								
		ju	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ience of):							
	uted nd ransit	l Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ence of):							
_	rificate be executed ng physician and as the burial - transit	n/Medical	UNPENDED	AMENDED				,				
8760		n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome		Fetal	death	3 Ectopic	pregnanc	ev	23d. Date of Month	delivery Day Year
9	s that the death certing gned by the attending detached for use a	Physicial	past 12 months? 1 Yes 2 No 9 Unknow	4 Pregnant at tim			(Specify)		programe	-	Monar	Day Tour
C	nat the		Part II. Other significant conditions	contributing to death b	ut not resulting	g in the und	lerlying caus	se given in Pa	irt I.			bute to the cause of death?
O.	uires that n signed t Id be deta	ed by									2 V No 3	
Division of Vital Records. P.O. Box	To the Hospital or Attending Physician: The law requires that the death cer- within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Completed							_	24a. Was a autop perfor	sy p med? d	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
<u>e</u>	cian: certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:				Other				
ž	ding Physic After this funeral dire	은	1 Yes 2 No 27. Manner of Death	inpatient		utpatient 3 Time of Inju		njury at Work			Residence 6 v	_
o u o	ending ath. or: Afl	tion	1 Natural 5 Pending		0530) hrs	1	Yes 2	lp,		struck by auto	
, Divisi	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide	ot be 28e. Place of Injury			factory, offic	e building, etc		or Town, S		er or Rural Route Number, City
<u>-</u>)	To the Hospital or A within 24 hours after To the Funeral Dire	Medical C	29a. Certifier 1 Certifying Physi	cian: To the best of my k								
-	T. W. I.O.	Me	29b. Signature and title of certifier	and manner stated.	\cap		29c. Lice	ense number			29d. Date signe	ed (Month, Day, Year)
			Carde	Hall	Leu	_	- 0.0	C.M.E.			March 25, 2	2007
RI	6)		30. Name and address of person who Carol Allan, MD Assist	o completed cause of dea tant Medical Examii		Penn Str	eet, Balti	more, MD	21201			
	Si Regis	ate	31. Date filed (Month, Day Year) MAR 2 9 2007	32. Registrar's	Signatur	D					-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1	1000	1	70.7		3	de	priest.	
' 1	6 3		7	3	1	8 1	for a	
/	1 6	1 1	1			Year 3	3	
C	S. J.	1	7	1			21	
				,		40		

		1- For State Registrar	Certific	cate of Death	Re	g. No.	1 1 1 0 0
Physici Medical Exami		Decedent's Name (First, Middle,Last) MARY		LIAMS	2. Date of Death Month April 2, 200	n Day Year	3. Time of Death 1600 hrs
		4a. Facility Name (if not institution, give street Doctors Community Hospital	and number)	4b. City, Town, or Location Lanham	of Death	4c. County of Death Prince George	
Funeral Director		5. Social Security Number 6. Sex 243-56-7487 1 M 2. Usual Residence of Decedent	7. Age (In yrs. last b	irthday) If Under 1 Year If Und Months Days Hours	er 24Hrs. 8. Date of Birth APRIL	(MM/DD/YYYY) 9. Birt 29 1927 Foreig Cou	hplace (State or n NORTH ^{untry} CAROLINA
Maryland 28a-f show any 1.at.once.	ō	10a. State 10b. County MD PRINCE GEO	RGE'S 10c. City, Tow	rn or Location			10d Inside City Limits 1 X Yes 2 No
th the Maryl 23a or 28a-1 notified at o	Dire	10e. Street and Number 5700 42nd AVENUE		10f. Zip Code 20781	10	g. Citizen of What Coun	
leath wi	nue	Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	S:	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican		14. Race - Americ White, etc. Specify: B	can Indian, Black,
21215-0036 bould be filed within 72 hours after of Mental Hygione. is marked other than "natural", of the event, the Medical Examiner in	Completed	11th	est grade completed) 16a	a. Decedent's Usual Occupation (Give during most of working life. DO NOT DOMESTIC		16b. Kind of Business/Ir	
21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) WILLIAM BROCKETT		18.Mother A'	's Name (First, Middle, M PTELINE VINE	aiden Surname) ES	
e, MD 21 1 and 2 should Health and Me item 27 is ma r traumatic ev	٩	19a Informant's Name/Relationship (Type, Pri DONALD BROCKETT/NEP		9b. Mailing Address (Street and Nur 3521 55th AVENU			
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition 1 X Burial 2 Cremation 3 Rem 4 Donation 5 Other Specify:	oval from State crema	e of Disposition (Name of cemetery, atory or other place) STEAD CEMETERY	4/7/2007	20c. Location - City or T	NORTH
		21. Signature of Funeral Service Licensee		22. Name and Address of Facility 7474 LANDOVER	ROAD LANDOV	ENKINS FUNE ER,MARYLANI	20785
Physician /M i l Examiner			dominal hemorrha		ardiac or respiratory arres	st, snock, or neart	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	or as a consequence of): foration of ilia or as a consequence of):	c arteries due to ste	nt placement		
ecuted and transit		events resulting in death) Last Due to (or as a consequence of):				
760, ficate be executed g physician and the burial - transit	/Medical	IF FEMALE: 23c.	b.PII,27,28a-	f, perME, g867, 5/29/	07 TT	23d. Date of delivery	
Box 687 ne death certific the attending p	sician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 9	Decree of the other of the other	2 Fetal death 3 Ectopic 5 Other (Specify)	pregnancy	Month Da	ay Year
P.O. res that the signed by the	ğ	Part II. Other significant conditions contrib Atherosclerotic cardiova		ng in the underlying cause given in Pa		acco use contribute to the 2 No 3 Proba	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial infansi.	Completed				24a. Was ar autops perform 1 🗸 Yes 2	prior to co ned? death?	opsy findings available ompletion of cause of
Vital I hysician: this certifi I director,	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	1 ✓ Inpatient 2 ER/0	26 Place of Death Outpatient 3 DOA Other	1	esidence 6 Other:	
Sion of \\ Attending Phy death. ctor: After the	-	27. Manner of Death 28a 1 Natural 5 Pending 2 X Accident Investigation	Date of Injury (Month, Day, Year)	Time of Injury 28c. Injury at Work	? 28d Describe ho artery wa	w injury occurred as ruptured an	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	OF	Suicide 6 Could not be 4 Homicide (S	pecify) hospita		Doctor's C	Community Hosp	ital Lanham, N
To the How within 24 h	Medical	one) 2 Medical Examiner: On the		eath occurred at the time, date and plate investigation, in my opinion, death oc	curred at the time, date ar		cause(s)
11 1		auetz	·	O.C.M.E.		April 4, 2007	
4.		30. Name and address of person who complete Ana Rubio MD. Assistant Med	· · ·	Penn Street, Baltimore, MD	21201		
St Regist	31.0	31. DAPR (10 6 2007)	32. Registrar's Signature	h			

Norman Kit Wong

March 26, 2007

11:28 pM

· de	Examin	er	4a. Facility Name ()			inder)		40. Oity, 104				40.0	ounty or Dea	
717	<u> </u>	2	Holy Cr 5. Social Security N	oss Hospi	tal 6. Sex	7. Age (In yrs. la	ast birthday	If Under 1 Y	ilver S	ler 24 Hrs. 8.	Date of Birtl	h	Montgo	mery thplace (State or Foreign
	Funeral Director		216-58- Usual Residence o	9261	1 ⊠ M 2□F	68	Yrs.	Months D	ays Hour	s Min.	(Month, Da) nuary	, Year)	C	ton, China
	and and		10a. State	10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Director	Maryland	Montgo	omery		Si	lver Spri						1 ☐ Yes 2 🙀 No
	or 28	Dire	10e. Street and Nu	ımber				10f. Zip Co	de			10g. Citize	en of What Co	ountry?
	ath w s 23a nust b		21	Wilcox (20906				U.S.	
	er de item: ner n	Funeral	11. Marital Status	-i 0.1971 8.40-mir	Armed Fo		5. 13.	Was Decedent If Yes, specify	of Hispanic Cuban, Mexi	Origin? (Specify can, Puerto Ric	Yes or No- an, etc.)	'	4. Race - Ame Black, Whit	
900	ours aft ral', or Exami	by	1 Never Mari		ed 1 Tes If Yes, Gi Year or D	ve		1□Yes 2█	No Spec	ify:		5	Specify:	Asian
5	72 h 'natu dical	ete	(Spec	15. Decedent' city only highes	s Education t grade completed)		(Give	dent's Usual O kind of work d DO NOT use re	one during n	nost of working		16b. Kind	d of Business	/Industry
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Seco	College (Willa	rd Inte	Hotel rcontinental					
and		Be	17. Father's Name	,	other's Name (Fi		Maiden S	lurname)						
Z	2 should be to and Mental I should be to I should b	욘	19a. Informant's N	Shet Wong			Chow Lee ral Route Number, City or Town, State, Zip Code)							
Z	5 = 2 ;			Wong - S		lver Spri				<				
ē,	ges 1 and 2 t of Health If item 27 I or other tra		20a. Method of Dis		_	20b. Pl	ace of Dispo	osition (Name o	of rolace)	Date		20c. Loca	ation - City or	Town, State
limo	Pages ment of l tant: If its jury or o		4 ☐ Donation	5 Other (Sp		State	e of He	eaven Cem	etery	4/2/200	07	Si1ve	r Sprin	g, Maryland
Ball	permit. Pag Department Important: I any Injury o once.		21. Signature of Fi	uneral Service L	icensee	+	1	2. Name and A Hines-Rin L1800 Nov	aldi Fu	neral Hon	e, Inc.	Var Sn	ring M	aryland 20904
-	CE TO SHE		23a, Part1. Enter I	the a sease, or	complications that conly one cause on	caused the death							iing, ii	Approximate Interval Between Onset and Death
	Physician		Immediate ause disease or condition											Onset and Death
	/Medical		resulting in death)	on	- u.	Atheroscle (or as a consequ		Jardiovas	cular D	isease				
	Examiner				h .	Sepsis								
	D #	ner	Sequentially list co if any, leading to in cause. Enter Unue Cause (Disease or that initiated events	mmediate	Due to	(or as a consequ	ence of):							
	icate be executed physician and s the burial-transit	Examine	Cause (Disease or that initiated events	r injury s	c									
68760,	oe execian a	Ě	resulting in death)	Last	Due to	(or as a consequ	ence of):							
87	cate k	dica		·	d									
Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceder			tcome pf pregnar		⊒Ectopic pregn	ancv			23	3d. Date of de	•
Ö	that the dea led by the att detached fo	nysick	in the past 12 1 ☐ Yes 2 l 9 ☐ Unknown	□No		nant at time of de		Other (specif					Month	Day Year
S, P	s that ned b deta		Part II. Other signi	ificant conditio	ns contributing to d	eath but not resul	Iting in the u	nderlying caus	e given in Pa	ırt I.	23e. Did to	bacco us	e contribute t	o the cause of death?
	w requires tha s been signed I should be det	d by									1 🗆 Y	′es 2 🗆	No 3□P	robably 4x Unknown
000	s bee	Completed								Ì	24a. Was a		24b. Were a	utopsy findings available
Ä	The law cate has page 2	mo l										sy rmed? 2 ⊠ No	prior to death? 1 □ Yes	completion of cause of s 2 □ No
ital		a	25. Was case reference	rred to medical	7				26. Pl	ace of Death (C				
<u>r</u> <	Physician: this certific al director,	To B	1 Yes 2 X	No	Hospital: 1	Inpatient 2 🔼 E	ER/Outpatie	nt 3□ DOA	Other: 4 🗆	Nursing Home	5 🗆 Resid	lence 6	□Other (Spe	ecify)
Division or Vital Record	ing Afte une		27. Manner of Dea 1 Action 2 Accident	th 5 ☐ Pending investig	1 '	of Injury oth, Day Year)	28b. Time o Injury		Injury at Work? 1 ☐ Yes 2		. Describe h	ow injury	occurred	
Nivis!	I or Attending affer death. I D rector: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could ne determin	nod Zoe. Flace	e of injury - At hor ling, etc. (Specify	me, farm, st	reet, factory, of	fice	28f.	Location (S City or Tow	itreet and n, State)	Number or R	ural Route Number,
	spital ours a reral filled		29a. Certifier (Check only		g Physician: To the Examiner: On the b									
	To the Hos within 24 h To the Fur completely	ledical	one)			ner stated 7							-	
	Ե業┖╘	Σ	29b. Signature and	title of certifier	1	1 U. J	201	29C. LR	cense numb	i	'		7 1	th, Day, Year)
	(3)		14	J./	4. X	~/	(U)		070	21		03/	27/2	2007
			30. Name and add		who completed cause. 1500 Fo				rine M	laryl and 3	010			
	Sta	te	31. Date filed (Mor	nth, Day, Year)	32 #	Agistrar's Signat	tire							
	Registr			WAR 3 0	2007	merce d	K A	medi						
DII	1941 47 D 4/D	001			-									

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

07-02659	
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7-02659		Please Type or Print in Black Indelible Ink. E			ble.	
dward William		otato o, marjama, 2 oparament o, mar		giene	0.0	07 1105
		1- For State Certificate of Deat		Reg.	No. 4 U	01 1170
Physicia		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month	ay Year	3. Time of Death 2022 hrs
ledical Exami		Edward William Appel		April 7, 200		
		, and the same of	Town, or Location of Death		4c. County of De Baltimore C	
h		Transmit educate treepitati		To Date of Birth		Birthplace (State or
Funeral Director		Montr		-	Fo	reign
Director	L	215-90-0323 1X M 2 F 41 Yrs. 1000		Sept 2	,1965	Country) MD
₽.	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			-	10d. Inside City Limits
м яну						1 Yes 2 No
faryland 28a-f show Lat once.	ğ		p Code	1100	. Citizen of What C	
Mary r 28a ed at	Director			109	. Gitizen of What C	outiny:
th the Maryland 23a or 28a-f sho	— L		220	anif . Van an Na	USA	nerican Indian, Black,
ith wi	a l	1 X Never Married 2 Married Armed Forces? If Yes, speci	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto		White, et	
er dea	Fun	1 Yes 2 X No	2 No specify:		Specify: Wh	•
rs aft ural" mine	ą	or Dates:	I Occupation (Give kind of w	ork done	6b. Kind of Busine	
2 hours a "natura Examir	ted		orking life. DO NOT use retir			
36 hin 7 e. than	ğ	11 N/A Electric	cian		Electri	cal Cont.
d with	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Ma	iden Surname)	
MD 21215-0036 12 should be filed within 72 hours after death with the Maryland th and Menial Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she umaric event, the Midical Examiner must be notified at once	Be	Edward O. Appel	Rita Sv	vann		
21 buld bulld by Mer		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres	SS (Street and Number or R	Rural Route Numb	er, City or Town, S	tate, Zip Code)
MD d 2 sho lth and n 27 is numati			yflower Rd.			
Te, l and l Heal f item		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Na crematory or other place		Date	20c. Location - Cit	y or Town, State
Pages ent of nt: I			matory 4-1	0-07	Baltimo	re. MD
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Mark		4 Donation 5 Other Specify: Bayview Cres 21. Signature of Funeral Service Licensee 22. Name and	d Address of Facility Kac	czorows	ki Fune	ral Home,PA
E P P E		Tobat Jocean 1201 1	Dundalk Ave	enue Ba	ltimore	, MD 21222
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	of dying, such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
M dical Examiner		Immediate Cause (Final disease a. Narcotic intoxication				Death
TAGIIIII		or condition resulting in death) Due to (or as a consequence of):				
	<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Ę	Cuse Enter Underlying Cause (Disease or injury that initiated				
* *	Examiner	events resulting in death) Last Due to (or as a consequence of):	-			
executed an and al - transit	calE	d				
Ox 68760, eath certificate be execute attending physician and for use as the burial - trar		X UNPENDED #23a,27,28a-f, perME, g867, 5	5/24/07 TT			
76(ficate ficate ficate	Š	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death		ancv.	23d. Date of del Month	ivery Day Year
certi	[평.	past 12 months?		anoy		
Boy e death the atte	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown				
C t		Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.			e to the cause of death?
res that signed be deta	Completed by			1 Yes	2 No 3	Probably 4 Unknown
rds requi	ete			24a. Was a autops		e autopsy findings available to completion of cause of
SCO le law te has ge 2 s	티			perform	ned? dear	h? Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requirs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should!		25. Was case referred to medical	26.Place of Death (Check			
Vita hysicia this cer	o Be	examiner? Hospital:	DOA Other Nursin	ng Home 5 F	Residence 6 0	Other:
n of V ling Phy After th funeral	-1	27 Manner of Death 28a Date of Injury 28b Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
onding ath.	흲	Natural 5 Pending (Month, Day, Year) Accident Investigation Fnd 4/7/2007 Fnd 7:14 pm	1 Yes 2 X No	unk		
isic r Atte er der irecto	Eg	28e. Place of Injury - At home, farm, street, factor	ry, office building, etc.			r Rural Route Number, City
Divisior pital or Attencours after death eeral Director:	Certification:	3 Suicide 6 X Could not be 4 House		3917 Mist	y View Rd.	Middle River, MD
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	he time, date and place, and	due to the cause	(s) and manner as	stated.
Fo the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in n and manner stated.	ny opinion, death occurred a	at the time, date a	nd place, and due	to the cause(s)
F ≥ F 8 !	ž		9c. License number		29d. Date signed	(Month, Day, Year)
		Vousite In o Ukall	O.C.M.E.		April 8, 2007	
X	ł	30. Name and address of person who completed cause of death (Item 23a)			····	
70		Margarita Korell MD. Assistant Medical Examiner 111 Penn S	street, Baltimore, MD	21201		
	tate					
Regis	trar					
DHMH 17 Rev 1/2	2001	ORIGINAL				

			State of Maryland / Departm	nent of Health and M cate of Death	ental Hygi	ene 007	11958
-	Physic	ion	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Paul Albrecht			1, 2007	11:00 A ^M
	Exami	ner		City, Town, or Location of Death		4c. County of Death	
	seen ton administrate assess			Rockville		Montgomer	-
	Funeral		177 M 2015 Mor	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Jan. 27,	(ear) 9. Birthpl	lace (State or Foreign try)
d.	Director		215-54-8173 NAME 2LIF 82 Yrs. Usual Residence of Decedent		Jan. 27,	1923 SLova	k Republic
	/land ow		10a. State 10b. County 10c. City, Town or Location	n		10	0d. Inside City Limits
	Many Fied	ţo	Maryland Montgomery Potomac				1 ☐ Yes 2 No
	r 28s	irec		Of. Zip Code	100	g. Citizen of What Coun	try?
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show lical Examiner must be notified at	Funeral Director	1201 Fallsmead Way	20854	U	nited State	S
	deat ms	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14 Yes.	Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - America	
9	after or Ite		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	es 2 No Specify:	nican, etc.)	Black, White,	ite
21215-0036	Jral",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				
5-("natu	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind of the completed)	s Usual Occupation of work done during most of workir IOT use retired)	g 16	6b. Kind of Business/Ind	,
121	withir	d m	Elementary/Secondary (0-12) College (1-4or 5+)	h Scientist		National In of Health	
2	Hygie Hygie ther	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First Middle Ms		
Maryland	ed o	Be	Henrik Albrecht			den Samane)	
Z	hould Me mark	2		Viera Ha		City or Town State Zin	Codel
Z	d 2 s Ith an 17 is trau			.11smead Way, Pot			854
	1 an Heal Hem 2		20a. Method of Disposition 20b. Place of Disposition 1 Thurist 2 Commetting 2 Democratic State cemetery, crematory			Oc. Location - City or To	
ē	ages ant of t: If II		Muldia 2 Colemation 3 Memoval non State	· Abri	1 17.	·	•
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Specify) Gate of Heave 21. Signature of Funeral Service Live see 22. Nam	en Cemetery 200 me and Address of Facility	/ ;	Silver Spri	ng, Maryland
Ba	permi Depar Impor any Ir		William a. Turphy M01173 Book	A. Pumphrey Funer Montgomery Avenu			
8			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	e mode of dying, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
The same of	Physician		Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer				Onset and Death
-	/Medical Examiner		Due to (or as a consequence of):				
10		<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	bed isit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usace or njury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
ь.	xecurand and	Examiner	that initiated events resulting in death) Last C				
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687	ficate phys		d				
Box (w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of deliver	n/
ğ	atter after for u	ciar	in the past 12 months? 1 Live birth 2 Li Fetal death 3 Li Ector	pic pregnancy er <i>(specify)</i>			Day Year
0	the cry the	iysi	9 ☐ Unknown 9 ☐ Unknown				
σ,	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlyi	ving cause given in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
Records,	quire; n sigi	d by			1 ☐ Yes	2 No 3 Proba	ably 4 🕅 Unknown
00	w rec	Completed			24a. Was an	24b. Were auton	sy findings available
æ	he lav e has age 2 :	m.			autopsy performe	ed? death?	osy findings available apletion of cause of
Vital			25. Was case referred to medical	26 Place of Death	1 Yes 2		2 No
>	Physician: The latter that the transfer of the	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	26. Place of Death Other:		ce 6 DOther (Specify	Daughter's
0	D 0		27. Manner of Death 28a. Date of Injury 28b. Time of		Bd. Describe how		Nesidence
Division	Attending r death. ector: After by the funer	Certification:	1 ☒ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M				
Vis	Atte	iji	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, farm building, etc. (Specify)	actory, office	Bf. Location (Stre	et and Number or Rural	Route Number,
Ö	al or	ert	Fullding, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation)	urred at the time, date and place, a	nd due to the cau	se(s) and manner as sta	ated.
	he H in 24 he Fi plete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	gation, in my opinion, death occurre	d at the time, dat	e and place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number		. Date signed (Month, L	
	,		Schemere Wullesty MI)	D0064615	AŢ	oril 12, 20	0/
1	1)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-			
1.	<i>~</i>			rd Drive, Suite	100, Roc	kville, MD	20850
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	· ·			
	Registr	ar	APR 1 6 2007 Days & April 1	5/			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Physician April 14, Rosalie D. Bonica 7:30 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Oak Crest Care Center Parkville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) 10/26/1905 **Funeral** 9. Birthplace (State or Foreign Country)
Italy 1 □ M 2 🗙 F Months 101 213-26-0837 Director Usual Residence of Decedent the Maryland or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Parkville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? è death with Examiner must be 8700 Maravoss Lane 21234 items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 6 1 ☐ Yes 2 X No Specify: ģ White Baltimore, Maryland 21215-003 3 ☐ Widowed 4 🎖 Divorced Specify: "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 5 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Social Security Admin. 12 Injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Gaetano Macaluso Maria Manganaro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Heatth at Important: If item 27 is any Injury or other trau Mrs. Patricia Marani / Daughter 8700 Maravoss Lane Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 100 Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Moreland Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 4/18/2007 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kimberly Davidson 5305 Harford Rd. VM Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760. Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform page certificate 1□ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death After 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 5 ☐ Pending investigation 1 Natural (Month, Day Year) Injury after death. М 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) an more D58646 April 16 200 > 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anns 8800 Mon 20: ug 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar APR 1 6 2007

			1 - For State Registrar	State of Ma	arylan		artment of tificate of		ind Me		jiene og. No.	007	1	960
	Physici		1. Decedent's Name (First, Middle, Las							2. Date of Deal	th Day -	3 Year		e of Death
	/Medio Examin		4a. Facility Name (If not institution, give MERCY MEDICAL (street and number)			4b. City, Town, BAL	or Location of		771 12	4c. Co	unty of Dea	101	20 ,,
	Funeral Director		5. Social Security Number 6. Se 216 05 12 9 2	2	9 (In yrs. 94	last birthday) Yrs.	If Under 1 Year Months Days			8. Date of Birth (Month, Pay) JULY4,	ľ912	9. Bi	thplace (St. ountry) rylar	ate or Foreign
	within 72 hours after death with the Maryland ane. 10. "Then "neture!", or fleme 23a or 28a-f ehow the Medical Examiner must be rediffed at	tor	10a. State 10b. County Md . n/a		10c. Cit	y, Town or Lo								le City Limits Yes 2 No
	with the	Director	10e. Street and Number 2909 Hudson St	reet			10f. Zip Code	21224		1	0g. Citizen	of What C	•	
	death	nerai	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U	.S. 13.	Vas Decedent of Yes, specify Cul			offy Yes or No-		Race - Am	erican India	n,
Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In important if them 27 is marked other then "neturel; or iteme 29a or 28a-1 ehow any injury or other traumatic event, the Medical Examinar must be indiffed at once.	d by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2€ → If Yes, Give Year or Dates:	lo		☐ Yes 2 🛣 No	Specify:	, rueito r	tican, etc.)		Black, Whi	Whit	е
215-	nin 72 3. 9n "net Medica	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		+)	16a. Deced (Give life. I	lent's Usual Occu kind of work done DO NOT use retire	pation during most ed)	of workin	g	16b. Kind	of Business	/Industry	
27	Hygien Hygien ther th	Con	7th 17. Father's Name (First, Middle, Last)		.,	Pair	nt Repa		de Namo	(First, Middle, I			Moto	S
yland	Mental Mental Merked of	To Be	Martin Bochins	ki						01sze		name)		
Mar	d 2 sho th and t7 is mu trauma		19a. Informant's Name/Relationship (T	PH IGGGS		Bassing and	g Address (Stree							1000
Baltimore,	es 1 an of Heal fitem 2 r other	3	Alice Katsiano		20b. P	face of Dispo	McShan sition (Name of patory or other pla						Town, Stat	
	it. Pag irtment irtant: I njury o		4 □Donation 5 □Other (Specify, 21. Signature of Funeral Service Licens)	St		nislaus Name and Addr							
Ba	Depa Impo any i		The March	and			201 Dun							
	hysician		23a. Part1. Enter the disease, or comp shock, or heart faifure. List only o Immediate Cause (Final disease or condition	lications that caused ine cause on each lin	θ.	•	er the mode of dy	ing, such as c	cardiac or	respiratory arre	est,		Onset a	mate Between and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseq									pa y
	2 =	Iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	uence of):							1 1	77 7
3760,	dean centincate be executed e attending physician and d for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. ACUTE Of Due to (or as a			C FENAL FAILURE						170	AR
289	ing physi	Medic	IF FEMALE:	o										
		Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 1 □ Live birth 1 □ Pregnant at 1 □ Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify) _	ey .			23d.	Date of de Month	livery Day	Year
ds, P.	pe de	þ	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.						23e. Did tob	accouse o			of death?
	has been sign 2 should I	Completed								24a. Was ar		b. Were a	utopsy findu	ngs available of cause of
r	tificate ha	e Con	OF West of the Control of the Contro							perform 1 Yes 2	ned? ZNo	death?	2 □ No	or cause of
ot V	us certifical	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatier	nt 2 🗆	ER/Outpatient	3□ DOA Ot			Check only one e 5 Reside		Other (Spe	cify)	
o uo	r death.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. Inju Wo		28	3d. Describe ho				
5	Ed hours after death Funerel Director:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At ho . (Specify	ome, farm, stre				3f. Location (Sti City or Town	reet and No , State)	mber or R	ural Route I	Vumber,
9	100	edicai (29a. Certifier (Chack only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of	examınaı	wledge, death tion and/or inv	occurred at the testigation, in my	me, date and opinion, death	place, an	nd due to the ca	use(s) and ate and pla	manner a	s stated.	se(s)
10.07	within 24 I	Mec	29b. Signature and title of certifier	and manner star	7		29c. Licen	se number	1 [25	9d. Date sig	ned (Moni	h, Day, Yea	(r) 0 0 0
7	11	Ì	30. Name and address of person who co	Months of day	ath (Item	23a) (Tuna 1	Print)	. 00 -	14		Hpr	1113	3,2	007
	0		Melissa PA	W 3	01.	St.P	aul,	Bal	tm	102l,	M7	5 6	77)2
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Registrar DHMH 17 Rev 1/2001

State

Kangena

32 Registrar's Signature

van

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Bea Apri 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bayview (enter Medical N/A If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 M 2 □ F Director 45 218-80-6931 Usual Residence of Decedent 1962 Maryland Apr. 6. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2☐No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2013 Larkhall Road 21222 United States 72 hours after death Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify Specify: ð 3 ☐ Widowed 4X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) 8 years Cab Dispatcher Transportation permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: If item 27 Is marked other any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert G. Beatty 2 Emily E. Siddons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk, Maryland 21222

Date 20c. Location - City or Town, State 2013 Larkhall Road Mrs. Emily E. Fifer (Mother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Other (Specify) Hilltop Service Corp. 4/13/2007 Towson, Maryland 21. Signature of Juneral Service Licens Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final respira Physician 36 hours disease or condition /Medical Due to (or is a consequent Examiner levra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed DO TOCE bunial-trar Due to (of as a consequence of): Box 68760, attending physician Physician/Medical the as nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the detached 9 Unknown 9 Unknown þ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2[]/No 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1- Natural 5 Pending investigation o the Hospital or Attendli ithin 24 hours after death. o the Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident the 6 ☐ Could not be 3 Suicide Place of injury \cdot At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) .othe Howithin 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore littani Avenue

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 16

32 Registrar's Signature

			1 - For State Registrar	State of Ma		epartment of F Certificate of			iene eg. No. 2007	11963
	Physic	an	1. Decedent's Name (First, Middle, La	st)		0 1		2. Date of Deat _ Month	h Day Year	3. Time of Death
	/Medi		Anna	···		Benton		APRIL	8 200	1 08:36 AM
	Examir	ner	4a. Facility Name (If not institution, giv	street and number)	/	4b. City, Town, o	r Location of Death		4c. County of Dea	th
			THE JOINS HO	Kins H	-Sfital	104/4	MULE	Y		
	Funeral		5. Social Security Number 6. S	ex 7.Age □M 2DXF	(If yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign
	Director		213-78-9120 Usual Residence of Decedent		85 Y	3.		APR. 29	, 1921	VA
	land ow		10a. State 10b. County		10c. City, Town	or Location		-		10d. Inside City Limits
	Mary	ţ	MD		BALTIM	ORF				1. Yes 2 □ No
	72 hours after death with the Maryland "natural", or Items 23a or 28e-1 show olical Exardinal most be rigitified at	Funeral Director	10e. Street and Number		PLATATITE.	10f. Zip Code		1	0g. Citizen of What Co	ountry?
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	deat ms 2	ner	11. Marital Status	12. Was Decedent 6 Armed Forces?	ver in U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race - Ame	
9	or the		1 Never Married 2 Married	1 ☐ Yes 2 🛣 N	0	1 ☐ Yes 2 No		rican, etc.)	Black, Whit	e, etc. ITE
93	ours Fig.	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		TO THE ZENIO	Sр ө спу:		Specify: WIT	
21215-0036		Completed by	15. Decedent's Ed (Specify only highest gra		(ecedent's Usual Occup Give kind of work done	during most of work	ing	16b. Kind of Business	/Industry
2		ig E	Elementary/Secondary (0-12)	College (1-4or 5	+)	ife. DO NOT use retire	d)			
	led v		7TH 17. Father's Name (First, Middle, Last,			OMEMAKER	40 Mathada Nam	- /Fires Adiabatta I	HOME	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	Be					18. Mother's Name		walden Sumame)	
Ĕ	d Mer d Mer nark	၉	TROY C. WRIGHT	Euro Ocioni	101		SARAH K			
Mai	12 st h and 7 le n traun		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street				Zip Code)
	1 and Health		HATTIE MAE NULL 20a. Method of Disposition			819 ORLEANS Disposition (Name of		-	MD 21224 20c. Location - City or	Town State
Baltimore,	in it		1⊠ Burial 2 ☐ Cremation 3 ☐		cemetery,	crematory or other place	ce)			
ţ	rtmer rtant njury		4 Donation 5 Other (Specif	·	GLEN	HAVEN			GLEN BURNI	
Bal	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Item ADGE.		21. Signature of Funeral Service Licer	-	/ /.	22. Name and Addre	WES	LEY CHAV	IS, JR. FN	RL. HM.
			man partition of the same	Char					TIMORE, ML	
			23a. Part1. Enler the disease of comshock, or heart failure. It only	one cause on each in	e.	t enter the mode of dyir	ng, such as cardiac (or respiratory arre	est,	Approximate Interval Between Onset and Death
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1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	:				
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	ed sit	in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of					
	The law requires that the death certificate be executed sie has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of	:				
8760,	be e sicien buria									
687	physics the street	ggl		d						
Box (eath certifica ettending ph for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy	-			23d. Date of de	iven
	etter for L	ciar	in the past 12 months?	1☐Live birth :		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		Month	Day Year
P.O.	that the de ned by the e detached f	ıysi	1 ☐ Yes 2 万 No 9 ☐ Unknown	9□ Unknown	,					
	res that igned b be deta		Part II. Other significant conditions of	ontributing to death bu	t not resulting in t	he underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ds	quires n sign	d by						1 □ Ye	es 2MNo 3⊟Pe	obably 4 Unknown
Records,	w require been si should l	Completed						24a. Was a	n 24b Were au	itopsy findings available
Re	he la e has	Ę						autops perforn	y prior to ned? death?	completion of cause of
ta		ပိ	25. Was case referred to medical				26 Place of Death	1 □ Yes 2	· ·	2 No
>	Physician: The law this certificete has traid inector, page 2 s	To B	examiner?	Hospital:	nt 2□ER/Outp	atient 3 DOA Oth	26. Place of Death		e/ ence 6 ⊡Other <i>(Sps</i>	out al
Division of Vital	Phys ar this aral di		27. Manner of Death	28a. Date of Injun (Month, Day)		ne of 28c. Injur			ow injury occurred	City)
io.	Attending r death ector: After by the fine	Ce tification:	1 ANatural 5 ☐ Pending 2 ☐ Accident investigation		Year) Inji		k? Yes 2 □ No			
Vis.	Afte cto by th	Hica	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju		, street, factory, office		28f. Location (St	reet and Number or Ri	ural Route Number,
ā	s after	ě	4 Homicide	building, etc	. (Specify)			City or Towr	i, State)	
	To the Hospital within 24 hours and the Funeral spmpletely filled		29a Cartifior (15) Cartifying Ph	ysiciam: To the best o	f my knowledge	foath consired at the tir	na, date and place.	and dua to the et	ard manner as	stated.
	n 24 n 24 he Ft	edicai	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	examination and/ led.	or investigation, in my o	pinion, death occurr	ed at the time, di	ate and place, and due	to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death To the Funeral Director: After th Sompletely filled in by the funeral	ž	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Mont	h, Day, Year)
	4		June 1	MEDILAL	DUCTOR	Der	+392	- F	PRIL 8	2007
1	10		30. Name and address of person who	completed cause of de	ath (Item 23a) (T	/pe, Print)				21767
	(Timothy Scialla	The Johns Ho	PKINS Ha	SPITRIL, 600	VORTH W	OLFE Str	eet Baitim	We MARTIAND
	Sta		31. Date filed (Month, Day Year)	2007 ^{32. Remstra}	r's Signature	Coule				-
	Regist	rar	ALUT (a south		- 8				

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Vital Records, P.O. Box 68760,	had been a to the contract of the state of t
0	DA
Division	author Assauding

			Please	Type or Prin							
			For State Registrar	State of Ma	aryland		artment of F rtificate of I	lealth and M Death	, ,	iene _{eg. No} 2 A A 7	11964
w 25	AL 11 13	2	1. Decedent's Name (First, Middle, La	st)					2. Date of Deat	th	3. Time of Death
	Physicia /Medic		JOHN G. BAUBLI	TZ, JR.					APRIL	13, 2007 Year	2:45 A.M
	Examin		4a. Facility Name (If not institution, giv	re street and number)			4b. City, Town, or	Location of Death		4c. County of Dea	th
3		5	GILCHRIST CENTE	R				SON		BALTIM	
	Funeral		5. Social Security Number 6. S	X	e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day)	Year) 9. Bir	thplace (State or Foreign ountry)
si i	Director		219-10-1671 Usual Residence of Decedent		81	115.			8/29/1	925 MA	RYLAND
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary I-f sh	tor	MD BALTIM	ORE		TOWS	ON				1 ∐Yes 2 ∭No
	or 282	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	ountry?
	th wit	a	8415 BELLONA LA	NE APT. 9	11		2120	4		USA	
	ems er mi	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
S S	or it	by Fu	1 Never Married 2 Married	1 X Yes 2 □ N If Yes, Give			1 ☐ Yes 2 💢 No	Specify:		Specify:	LITTOR
9 9 9 9	hours tural' al Ex		3 XWidowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	WWII	16a Dece	dent's Usual Occup	ation		16b. Kind of Business	HITE
<u> </u>	in 72 i "na" ledic	olete	(Specify only highest gr	ade completed)		(Give	kind of work done of DO NOT use retired	during most of worki	ing	TOD. TAILE OF DUSINESS.	madatry
7	with giene r thai	Completed	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5)+)	CLER	K			B & O RAI	LROAD
2	other other rent,	BeC	17. Father's Name (First, Middle, Last)	•	-V-1-1-11		18. Mother's Name	(First, Middle, I	Maiden Surname)	
ıand	uld be denta rked rlc ev	To E	JOHN G. BAUBLIT	Z, SR.				GRACE	DELANEY		
Mary	2 sho and 1 is ma auma		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or Rura	al Route Number	, City or Town, State,	Zip Code)
	and sealth n 27		JOAN A. PEARSON/	DAUGHTER			AY COURT	CATONSVI		21228	
9	ges 1 t of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐	Removal from State	20b. Plac	ce of Dispo netery, crei	osition (Name of matory or other plac	ce)	Date	20c. Location - City or	Town, State
Бантто	t. Partmen tant: ijury		4 □ Donation 5 □ Other (Speci	,	METF	RO CRI	EMATORY,			CATONSVIL	
מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	nsee Hay b			2. Name and Addre	11.			HOME, P.A.
			23a. Part1. Enter the disease, or com	pplications that caused	the death.	Do not ent	or the mode of duir	RAVEN BLV	or recoiratory arr		1286 Approximate
O	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on dach lir	ne.	° 10 -	1 : 0	ne um,	ni h		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as	a conseque	nce of):	ion f.		7 25		week.
	Examiner		Commentally lies and disease	h	0						
	pe tie	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	nce of):					
_	executed in and ial-transit	хагл	Cause (Disease or injury that initiated events resulting in death) Last	c	a conseque	nce of):					
ב ב		-	· ·	202 12 (2. 112	,						
200	certificate be nding physicia ise as the bur	Physician/Medica		_d							
X O	n cert	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			⊒Ectopic pregnancy	,		23d. Date of de	livery
-	death re atten	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (specify)			Month	Day Year
٦ ک	at the	Phy	9 Unknown						OD- Distant		- 4b
Š	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions	contributing to death b	ut not resulti	ing in the u	A L	en in Parts.		bacco use contribute t	robably 4 Unknown
ecoras	requ	eted	Cil d	101-	2000	10.7	7 700 //				
ě	The law ate has b	Completed	Jailen , Ce	avere '	na	w (iii	•		24a. Was a autops perfor	sy prior to med? death?	utopsy findings available completion of cause of
	n: Th		25. Was case referred to medical					OC Plans of Parel	1□ Yes	2☐No 1☐Yes	s 2□No
	Physician: The lav this certificate has ral director, page 2 a	To Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2∏EF	R/Outpatier	nt 3 DOA Oth	er: 4 Nursing Ho		ence 6 dother (Spe	with Hospice
פר	g Phy ter thi		27. Manner of Death	28a. Date of Inju (Month, Da	ry 2	28b. Time o Injury	f 28c. Injur Wor	y at		ow injury occurred	isany) (Y
SION	Attending r death. ector: After by the funer	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	, , , , , ,	,,		Yes 2 □ No			
Ž	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ury - At hom c. <i>(Sp</i> ec <i>ify)</i>	ne, farm, str	reet, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
_	pital ours at eral Diffilled	I Ce	29a. Certifier 1 Certifying P	hysiclan: To the best	of my knowl	ledge deat	h occurred at the ti	me date and place	and due to the o	rausa(s) and manner a	e etated
	e Hos 24 hc e Fun letely	ledical	(Check only 2 Medical Exa	miner: On the basis of	f examinatio	on and/or in	vestigation, in my	ppinion, death occur	red at the time, o	late and place, and du	e to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of gertifier	1'0			29c. Licens	e number	. 2	9d. Date signed (Mon	th, Day, Year)
ì	ox (Il Hush	7 Kly	ine	U	12	5 205	/	Hpril (5,2007
	gx'		29b. Signature and title of gertifier 30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of d	eath (Item 2	23a) (Type,	Print) N. Cla	ales 11	Bul	to me ?	21204
	Sta	te	31. Date filed (Month, Day, Year)	32. R egistr	ar's Signatu	re	(a . M a				
	Registr		APR 1 6	2007 1	أنكمر صيالية	The Age					
		204		1							

			1- State of Maryland / Dep	ertment of Health and Nertificate of Death	Mental Hygiei Reg.	2007 11065		
	Physici /Medic		Decedent's Name (First, Middle, Last)	BELLMAN	2. Date of Death Month	Day Year 2, 2007 9:00 P. M		
	Examir		4a. Facility Name (If not institution, give street and number) MANOR CARE TOWSON	4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE		
S.P.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 216-01-5368 1X M 2□F 91 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) 4/1/1916			
	/aryland f show ed at	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1		
	th the Nor 28a- e notifi	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?		
	ath wil		8542 PLEASANT PLAINS ROAD	21286		USA		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE		
1215-0036	hin 72 hou e. In "natura Medical E	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16b	WITTE.		
717	ed with	Com	12TH GRADE	MACHINIST		BETHLEHEM STEEL		
ian	e d la be	To Be	17. Father's Name (First, Middle, Last) FREDERICK BELLMAN	18. Mother's Nam MARY BO	e (First, Middle, Maid OSLEY	den Surname)		
Mary	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic			ling Address (<i>Street and Number or Rui</i> 2 PLEASANT PLAINS I		ty or Town, State, Zip Code) SON, MD 21286		
_	s 1 and f Health item 27 other tr	1.7	20a. Method of Disposition 20b. Place of Disposition			Location - City or Town, State		
Ē	Page ment o ant: If		1 Burial 2 Acremation 3 Hemoval from State		13/2007 CA	TONSVILLE, MD		
Baltimore,	permit. Pages 1 Department of F Important: If ite any injury or ot once.		1/2 / / / / / / / / / / / / / / / / / /	22. Name and Address of Facility TH		FUNERAL HOME, P.A. DN, MD 21286		
	Physician	Syptem	23a Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death		
	/Medical Examiner		ue to (r as a consequence of:	abilis unhary	tracta in			
/	ecuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C.	· ·				
8/60,	icate be executed physician and s the burial-transit	dical E	Due to (or as a consequence of):					
O. BOX 6	eath certif attending for use a	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year		
ds, P.	The law requires that the de ate has been signed by the a page 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the	23e. Did tobacc	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Vunknown			
Hecord	sician: The law rec certificate has beer irector, page 2 shou	Completed by			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?		
<u>ra</u>		a	25. Was case referred to medical	26. Place of Deat	1 Yes 2 ☐	No 1 ☐ Yes 2 ☑ No		
> -	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatie		ome 5 Residence	e 6 □Other (Specify)		
	nding P th. : After i s funers		27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation 28a. Date of Injury (Month, Day, Year) Injury		28d. Describe how in	njury occurred		
UIVISION	al or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, fate)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)		
)	To #	M	29b. Signature and title of certifier MD	D H 10 H	29d.	Date signed (Month, Day, Year) 4-13-07		
	V		30. Name and address of person who completed cause of death (Item 23a) (Type Teu Houk 7825, York R	Print) Jowson	m) 2	21204		
	Sta Registi		31. Date filed (Month, Day, Year) 32. Redistrar's Signature APR 1 6 2007	Joseph				

State Registrar

DHMH 17 Rev 1/2001

6701

N. Charle street Towson Ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WW

32. Registrar's Signature

Maries

31. Date filed (Month, Day, Year) APR 1, 6, 2007

			State of Maryland / Departm	nent of Health and cate of Death		0.0	09 1106
	- 64		1. Decedent's Name (First, Middle, Last)	cate of Death	2. Date of Dea	th	3. Time of Death
	Physicia		Gerald David Bazzell		Month 4	Day	Year 007 11:40 b
	/Medic			City, Town, or Location of De	1	4c. County	
			6209 Eunice Ave.	Baltimore	9		
	Funeral		Mor	Inder 1 Year If Under 24 H	rs. 8. Date of Birth n. (Month, Day	(Year)	Birthplace (State or Foreign Country)
ċ	Director		218-40-0927 124 M 2 L F 64 Yrs. Usual Residence of Decedent		12/15	/1942	Maryland
	and w		10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City Limits
	Marylan f show led at	ō	MD Baltimore Balt	imore			1 XYes 2 No
	r 28a	irec	10e. Street and Number 10	f. Zip Code	1	10g. Citizen of V	Vhat Country?
	h with	Funeral Director	6209 Eunice Ave.	21214		IJ	SA
	ems ems	ıner		Decedent of Hispanic Origin? , specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		e - American Indian, k, White, etc.
2	or it	by Fu	1 Never Married 2 Married 1 Yes 2 No	es 25 No Specify:		Specify	7. 1. 1
Ś	hours tural' al Ex	o b	3 ☐ Widowed ♣CPivorced Year or Dates: 15. Decedent's Education 16a. Decedent's	Usual Occupation		16h Kind of Bu	usiness/Industry
2	in 72 r "na" ledic	Completed	(Specify only highest grade completed) (Give kind of life, DO No	of work done during most of w OT use retired)	vorking		•
7	l with jiene. r thar the N	E O	Elementary/Secondary (0-12) College (1-4or 5+)	k Driver		Olymp Auto	Parts
2	al Hyg other /ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle,		
g	uld by Ments Irked Itic ev	ToE	Joel Bazzell		Ester 1	Bixler	
<u></u>	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M			dress (Street and Number or			, , - : - : /
<u>≥</u>	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene, maturall, or items 23a or 28a-f show flem 27 is marked other than "naturall, or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			Najoles Ro			•
5	permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2€€ remation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cremator F.Vans Film	y or other place) \ \rac{1}{2} \rac{1}{2}	ril 14		City or Town, State
	it. Partmer	-		Bel Air 20 ne and Address of Facility	0007		t Hill, MD
Ö	permit. Pages 1 Department of I Important: If Ite any Injury or ot once.		Evan	s Funeral C emation Ser	hapel	8800 Ha Parkvi	arford Rd. lle, ^{MD} 21234
			23a. Pany. Enter the disease, or complications that caused the death. Do not enter the				Approximate
	Physician ¹		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ncev			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):				Suros
	Examiner		b				
6	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
8.	ecute and trans	Examiner	that initiated events				
5	cate be executed physician and the burial-transit		Due to (or as a consequence of):				
00	physics the last	dical	d				
Y	death certifica attending ph d for use as th	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Dat	te of delivery
ă	death a atte	icial	in the past 12 months? 1□Live birth 2□Fetal death 3□Ecto 1□Ves 2□No 4□Pregnant at time of death 5□Othe	pic pregnancy er (specify)			nth Day Year
)	t the by the	hys	9 ☐ Unknown				
'n	gned be del	ру Р	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.	1		ribute to the cause of death?
5	equin	ted			- <u>'8</u>	es 2 No	3 Probably 4 Unknown
נ	law ras be	ple			24a. Was a autop:	sy r	Were autopsy findings available prior to completion of cause of
E .	: The cate h	Completed			perfor 1□ Yes	med? c 2DNo 1	death? I □ Yes 2 □ No
<u> </u>	icertifi ector	Be	25. Was case referred to medical examiner? Hospital: Hospital: 4 Discrete A DESCONDANCE AND ADDRESS OF THE PROPERTY OF THE PR	Other:	eath (Check only or	ле)	
5	Phys r this ral dir	. To	1 ☐ Yes 2 ☑ No	4 Nursing	Home 5 Resid	ence 6 Oth	
5	ding th. Afte fune	cation:	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	28c. Injury at Work? I 1 ☐ Yes 2 ☐ No	200. 2000.12011	on injury occur	
2	Atter r deal ector by the	fica	3 Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (S	treet and Numb	er or Rural Route Number,
5	s afte	Certifi	a mulang, etc. (apealy)		City or Tow	n, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical (29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or investig	urred at the time, date and pla	ace, and due to the o	cause(s) and ma	anner as stated.
	the hin 24 the F	Medi	one) and manner stated.	29c. License number			
	o d wit	-	290. Signature and title or certainer	1			d (Month, Day, Year)
		}	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 1300		^	2007 ipolis, lud,
	10+1		Stuant E. Selouich, w	900 Best	jute Kd.	HUNG	ipolis, und,
	Sta		31. Date filed (Month, Day, Year) 32/Registrar's Signature	9			
	Registr	ar	ADD 1 6 2007 Land St. ADD 44				

		Please T	ype or Prin						-		.egible		
		For State	State of Ma	aryland				Men	tal Hy	giene		. 7	
		1 - State Registrar			Ce	rtificate of	Death			Reg. No.	200	L_	11300
Physic	ian	Decedent's Name (First, Middle, Last)	Lotus Le	e Bor	nar			1	Date of Dea	Day	Yea	r [3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give s		bo DOI	HWT	4b. City, Town, o	or Location of De		pril	11,	2007 County of De	_	12:10 P ^M
Exami	ner	4510 Cheltenham Di				Bethe					ontgon		
Funeral		Social Security Number 6. Sex	7. Age	e (In yrs. las	t birthday) If Under 1 Year Months Days		rs. 8. [Date of Birt Month, Day	h	9. B		ce (State or Foreign
Director		5//-/4-5633]M 2∏F	80	Yrs.	World S Buys	Tiours IVII				927 Ko	res	,
and and t		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or L	ocation			-			10d	. Inside City Limits
Maryl -f sho lied a	tor	Maryland Montgome	erv		Re	thesda							1 ☐ Yes 2 No
h the rr 28a	Director	10e. Street and Number	J			10f. Zip Code				10g. Citiz	en of What	Country	?
th wit 23a c ast be	a	4510 Cheltenham Di	rive				20814			Unit	ed St	ntes	3
r dea tems	Funeral		12. Was Decedent I Armed Forces?		13.	Was Decedent of H	Hispanic Origin? an, Mexican, Pu	(Specify erto Rica	Yes or No n, etc.)	- 1	4. Race - Ar Black, Wi		
s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		1 ☐ Yes 2 🎇 No	Specify:				Specify:	Asia	An
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dieal Examiner must be notified at	edt	15. Decedent's Educ			16a. Dece	edent's Usual Occu	pation			16b. Kin	d of Busines	ss/Indus	strv
hin 72 In "na Media	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	+)	(Give life.	e kind of work done DO NOT use retire	during most of w	vorking					/
d with	E O	12		''	Hon	memaker /	Artist			Ow	n Home	0	
tal Hydoth	Be (17. Father's Name (First, Middle, Last)					18. Mother's N	lame (Fir	st, Middle,	Maiden S	Surname)		
y Monould	မ	Yi Tech Sue					Sun T						
d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (Typ		1		ing Address (Street							ŕ
Heal Heal tem 2		Diana L. Matthews 20a. Method of Disposition	/ Daughte			l Leman L position (Name of tematory or other pla		Date			ry Land		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at onee.		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State			ek Cemete		ril 2007		Wash	ingtor	, D	C
mit. I		21. Signature of Funeral Service License	e ,			22, Name and Addre Obert A. Pu							
		Magdettess	annut M	01305	7.	557 Wiscons	in Avenue	, Betl	hesda,	Mary!	saa-uns Land 208	vy (314–;	nase, inc. 3501
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused ne cause on each lir	the death. ne.	Do not er	nter the mode of dyi	ng, such as card	liac or res	spiratory a	rrest,		- Ir	pproximate nterval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	. Ath	erosc1	Lerot	ic Heart	Disease						nset and Death
/Medical Examiner		Tobalang in doutin	Due to (or as	a conseque	nce of):								
\$ - \frac{1}{2}!	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):								
cuted id ansit	Examiner	i inai inilialeo evenis 📰 🙃											
be executed ician and burial-transit	I Ex	resulting in death) Last	Due to (or as	a conseque	nce of):								
eath certificate be executed attending physician and for use as the burial-transit	dica	€ d	l						-			-	
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atten for u	cian	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal d	eath 3	□Ectopic pregnand □ Other (specify) _	У			2	3d. Date of o Month	D	ay Year
at the de by the tached	hysi	1 ☐ Yes 2 M No 9 ☐ Unknown	9□Unknown										
res that	by P	Part II. Other significant conditions con			-	, ,	ven in Part I.		23e. Did to	obacco us	se contribute	to the	cause of death?
w require been signature		Chronic Obstructi	Lve Pulmor	nary D)isca	Se		-	1 🗆 `	Yes 2	No 3	Probab	oly 4 ⊠Unknown
e law I has be	Completed							_	24a. Was autop	osy	24b. Were prior t	autops o comp	y findings available letion of cause of
Physician: The k									perfo 1□ Yes	rmed? 2∏ No	death 1 ☐ Y	? es 2	□No
siciar certif rector	Be	25. Was case referred to medical examiner?	lospital:		2/0	Oti Oti	26. Place of D						
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ath. rr: Afte	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	/ Year)	Injury		rk?]Yes 2 □ No						
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubuilding, etc	ury - At hom c. (Specify)	e, farm, s	treet, factory, office		28f.	Location (S City or Tox	Street and vn. State)	Number or	Rural F	Route Number,
urs aft													
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, to	Medical	29a. Certifier 1 X Certifying Phys (Check only 2 Medical Exami)	ner: On the basis of and manner sta	f examinatio	edge, dea on and/or i	ith occurred at the t investigation, in my	opinion, death o	ace, and ccurred a	due to the at the time,	cause(s) date and	and manner place, and c	as stat lue to tl	ed. ne cause(s)
To the	Me	29b. Signature and the of codifier		, 1	,	29c. Licen	se number			29d. Date	signed (Mo	nth, Da	ıy, Year)
		1/1/VA	1	1	h	D2	0516			Ap	ril 11	, 2	007
10		30. Name and address of person who co											
	ate	Joel R. Schulman, 31. Date filed (Month, Day, Year)	M.D. 60	00 Ex	ecut:	ive Blvd.	, Ste. 3	300,	Rock	ville	, Mar	y1a	nd 20852
Regis		APR 1 6	32. Regultra	was.	H.	Goods							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Manth 4 13 Ž007 09:00pm **Physician** Regina Mary Colegrove /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Severna Park Severna Park Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/14/1925 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days maryland 1 ☐ M 2 🔀 F 81 212-20-5631 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show a 1 ☑ Yes 2 ☐ No notified Harford Aberdeen MD Directo 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ed other than "natural", or items 23a or event, the Medical Examiner must be U.S.A. 21001 Apt. 407 901 Barnett Lane Pages 1 and 2 should be filed within 72 hours after death \nent of Health and Mental Hygiene. \text{int: If item 27 is marked other than "natural", or items 23: Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Specify: White Baltimore, Maryland 21215-0036 2 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Czaja Walter Koros P other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Hillcrest Ave. Gladstone, NJ 07934 Sharon Engelman, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hydes, Maryland 104/17/2007 Johns Long Green 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service License 5305 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -e ast مل و Con Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. End of the cause of cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ Ro 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1∐ Yes certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ this After thi 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Feertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours arren over to the Funeral Director: Af

31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier

20

1), Dorat Diva Cherk, Mis 2/6/9 08 2. Registrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

6

29c. License number

1) 32 63 6

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	•	Certifica:				Reg. No.?	007	11970
	Physici	an	1. Decedent's Name (First, Middle, L.	,					2. Date of De Month	Day	Year	3. Time of Death 7 5 2 48 AM
	/Medic	al .	Roy CARRA 4a. Facility Name (If not institution, gi			4b. City	Town, or	Location of Death	April	7	ounty of Dea	
	Examin	er	Lohns Hopkins		Letal Cen	ter		timore				
30.0	Funeral Director		5. Social Security Number 6.		(In yrs. last birthe	day) If Unde	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da JUNE 4	th y, Year) , 192	C	thplace (State or Foreign ountry) PA
	/land ow at		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	e Mar la-f sh tified	Director	MD		BALTIMO	RE						1 ŽYes 2 □ No
	vith th	Dire	10e. Street and Number			10f. Zi	p Code			-	n of What C	ountry?
	ns 234	Funeral	2828 MONTEBELLO 11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dece	edent of H	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No	USA 1	1. Race - Am	erican Indian,
920	be filed within 72 hours after death with the Maryland ital Hygliene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		lf Yes, spe 1 ☐ Yes		an, Mexican, Puerto	Hican, etc.)		Black, Whi Specify: W	te, etc. HITE
21215-0036	72 ho 'natur dical I	Completed	15. Decedent's 1 (Specify only highest g	Education rade completed)	16a. D	ecedent's Usi Give kind of w	al Occup ork done	eation during most of work d)	king	16b. Kind	d of Business	/Industry
121	within iene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+	-)	CARPEN		a)			ONSTRU	ICTION
	il Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Las	it) UNK		CHU DA		18. Mother's Nam	e (First, Middle			
/lan	should be ind Mental marked o	To B						SHIRLE	Y DALTO	NN		
Maryland	12 sho		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State									Zip Code)
	1 and Health tem 27		PATRICIA HUNT/D	AUGHTER	20b. Place of D	Disposition (Na	me of	412/16	Date BAL			r Town, State ISON FOREST
moğ	Pages nent of I ant: If Ite ury or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			crematory or RISON I						ISON FOREST LS, MD 21117
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumattc.		21. Signature of Funeral Service Lic)	22. Name a	nd Addre	ss of Facility WES		WIS,	JR. F	NRL. HM.
	Dhadala	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final										Approximate Interval Between Onset and Death
j e	Physician /Medical		disease or condition resulting in death)	a	consequence of):						5 days
16	Examiner		Sequentially list conditions.	Ψ,	monia							2 weeks
No.	ted nsit	Sequentially list conditions, if any, leading to immediate cause. Chiter Underlying Cause. (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Uninary Tract Infection Due to (or as a consequence of):								2 weeks		
68760,	tificate be executed g physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence of):		1-01000				
687	tificate g phys as the	edical		d								
.O. Box	that the death cert ed by the attendin detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal death	3 □Ectopic 5 □ Other (s		у		23	3d. Date of de Month	elivery Day Year
Δ.	w requires that is been signed by should be detail	by	Part II. Other significant conditions	s contributing to death bu	t not resulting in	he underlying	cause giv	en in Part I.				to the cause of death? Probably 4 Unknown
Division or Vital Records,	The la ate has page 2	Completed							24a. Was auto perfe 1□ Yes		24b. Were a prior to death?	autopsy findings available completion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			OA Oth	26. Place of Dea		-		
on or	ing Phys After this tuneral dir	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Ti	me of ury	28c. Inju	4 LI Nursing H	ome 5 Res 28d. Describe			ecify)
Divisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be Dece of inju	ry - At home, farm . (Specify)			1163 2 110		(Street and own, State)	Number or I	Rural Route Number,
	e Hospital of 24 hours are Funeral Cletely filled i	Medical Co	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination and	death occurre /or investigation	d at the ti	ime, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) e, date and	and manner and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	711		2	9c. Licens	se number		29d. Date	signed (Mo	nth, Day, Year)
): friMe	tale			KES	-000		Apri	17,	2007
0	T	,	30. Name and address of person who Jevan McFad	den M-D	eath (Item 23a) (1	ype, Print)	tern	Avenue	, Baltin	more	_, MD	2007 21224
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 6	2007 32. Figistra	r's Signature	ASSES						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day April 10, 2007 2330 hrs Medical Examiner CATRINA MARIE CUSIMANO 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** Harford Road & Hartley Mill Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreian Months Davs Hours Director 219-98-2070 9/28/1981 Country) MD 2X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No BALTIMORE GLYNDON 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 42 CRAFTSMAN COURT 21136 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 XNever Married 2 Married Yes Specify: WHITE If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 MAGAZINE 4 YEARS **EDITOR** 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, Be JOSEPH P. CUSIMANO MARY BEAMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD GREENBACKVILLE. STEPHEN BEAMAN/GRANDFATHER 3464 CAPTAINS CORRIDOR 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State METRO CREMATORY, INC. 4/16/2007 CATONSVILLE, MD Other Specify 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, onature of Funeral Service Licen TOWSON, 21286 8521 LOCH RAVEN BLVD. MD Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Retween Onset and failure. List only one cause on each line Death Wedley a. Head and neck injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED ending physician use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown the detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ficate has been signed by page 2 should be detach Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed' death? certificate has 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) fo the Hospital or Attending Physician: director, 25. Was case referred to medical Division of Vital Be Other₄ examiner? Nursing Home 5 Residence 6 V Other: Scene Hospital: 1 Inpatient 2 DOA ER/Outpatient 3 this 1 🗸 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Apr 10, 2007 27. Manner of Death Driver auto fixed object collision 2318 hrs Natural 1 Yes 2 V No death. Pending within 24 hours after death To the Funeral Director: 2 🗹 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State)
Harford Road & Hartley Mill Road, Glen Arm, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie April 11, 2007 mos O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

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			State of State of Registrar	Maryland / Dep	artment of H			giene	11972		
	N a		Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death		
П	Physici		Vincent DiMarco				April	16,2007	10:25a M		
7	∀Medio Examin		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or	Location of De		4c. County of Death	,		
			Genesis Hamilton Cer	nter	Baltime						
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	land		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits			
	Many f sho	ō	MD	Baltimo	ore				1 X Yes 2 □ No		
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Cour	itry?		
	h with		6040 Harford Road		21214	4		USA			
	deat	Funeral		dent Ever in U.S. 13.			? (Specify Yes or No- uerto Rican, etc.)				
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5-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Da	tes:							
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Ž	and 2 lealth a m 27 i		Theresa Fondelheit				Elkridge	Maryland	21075		
Baltimore, Maryland 2121	es 1		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from S	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	e)	Date	20c. Location - City or To			
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3alt	permit. Departr Importa any Inj once.		21. Signature of Funeral Service Licensee					Zannino d			
	9.0 E # 9	Ni !	Maria Higan					timore, MD	21224		
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J.	at the	Physician/Med	9 LI ONKHOWN								
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Vital Records,	requir	Completed by	todime our	orsear	<u></u>		_ 1 O Y	'es 2 No 3 Prob	ably 4 🖽 fiknown		
ပ္	law nasb	nple					24a. Was a autop	sy prior to con	psy findings available npletion of cause of		
		Con			····		perfor 1□ Yes	med? death?	2 No		
<u> </u>	ician Sertiffi ector	Be	25. Was case referred to medical examiner? Hospital:	-	Othe		Death (Check only or				
0	This P	7	1 ☐ Yes 2☐ No ☐ Hospital. 1 ☐ Ir 27. Manner of Death 28a. Date of	patient 2 ER/Outpatie		4 🗖 Nursin		ence 6 Other (Specif	y)		
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5	a 를 들 드	ertii	4 Homicide determined buildin	g, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow	n, State)	a riodie riomber,		
	e Hospital or 124 hours afte e Funeral Dire		29a. Certifier 1 CertifyIng Physician: To the	pest of my knowledge, dea	th occurred at the tin	ne, date and pl	ace, and due to the	cause(s) and manner as s	tated.		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the ba	sis of examination and/or ir	nvestigation, in my o	pinion, death o	occurred at the time, o	date and place, and due to	the cause(s)		
	To the I within 2. To the I complet	M	29b. Signature and title of certifier	0	29c. License			29d. Date signed (Month,			
	1) SUNDA	M		3146	, 4	41161	07		
1	1		30. Name and address of person who completed cause	of death (Item 23a) (Type	Print)		0 0	3. 0 171	7100112		
- (X		SHOALIZ A. HATHONI	M) 821	N. EUT	AW =	SI smite	368 BAI	m0 21201		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Re	ristrar's Signature	booker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 12 State of Maryland 1 Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Dav Physician MICHAEL DOLGOFF ADRIL 10 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HESPITAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) (State or Foreign Funeral 1 M 2 □ F 218-38-3420 67 Director 06/24/1939 MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MĐ N/A BALTIMORE 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3817 LABYRINTH ROAD 21215 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes - 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No WHITE Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN HOME IMPROVEMENT permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALLEN DOLGOFF GOLDIE LERNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCENE DOLGOFF / WIFE 3817 LABYRINTH ROAD - BALTIMORE, MD 21215 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition HEBREW ORTHODOX MEMORIAL SOCIETY 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/13/2007 BALTIMORE, MD 21. Signature of Funeral Service/Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part . Ent / the disea e / r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner POSITIVE CORRE Sequentially list conditions, if any, leading to infinite nate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Due to (or as a consequence of). Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown CHRDIOMIOPA THEY. CONGESTIVE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 25. Was case referre to medical examiner? To 2010 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Division or Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 6 within 24 hours aft To the Funeral Di completely filled in 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) he April 10, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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B.CONANTA

32. Registrar's Signature

ORCANDO

31. Date filed (Month, Day, Year)

APR 1 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Charlotte June Fiorino /Medical April 9 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Riverview Nursing Home Essex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min Director 79 June 9, 1927 Maryland 220-24-7528 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7547 Ives Lane 21222 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ any injury or other traumatic exercise. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify White þ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 years Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Schwing Edward Homer Dannettel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1849 Deer Park Road Finksburg, Maryland 21048 Rose Lambert (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State → Donation 5 Other (Specify) Most Holy Redeemer Cem. 4/12/2007 Baltimore, Maryland 21. Si natura f Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 212 Y Approximate Interval Between Onset and Death 2 - 3 www. a. Part I. Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. 3mokes Immediate Cause (Final 6 woven **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ √o autopsy performed' certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

3. Time of Death

11:30 aM

1 ☐ Yes 2 No

within 24 hours a To the Funeral I

State Registrar 29b. Signature and title of certifier

NASEEM 32 Registrar's Signature 31. Date filed (Month, Day, Year) APR 16 Charles .

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

709.

29d. Date signed (Month, Day, Year)

M.D - 2/221

04-10-2007

07-025	16
Bobby	Freeman

Sobby Freeman		State of Maryland / Department of Health and Mental For State Amend #5&11 Per INF Gold till Cale of Beath	lygiene Re	eg. No. 200	17 1107
Physician	1	Registrar 1. Decedent's Name (First, Middle,Last)	Date of Deat Month	h Dav Year	3. Time of Death
Medical Examine		BOBBY LEE FREEMAN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	April 2, 20	4c. County of Deal	1150 hrs
War and a		Johns Hopkins Hospital Baltimore	•		
uneral		5. Social Security Number 1 (6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	_	th(MM/DD/YYYY) 9. Bi	
Director		214-72-9409 1X M 2 F 46 Yrs. Months Days Hours Mi	OCT. 1	17, 1960 °	ountry) MD
any	- ⊢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		MD BALTIMORE			1 X Yes 2 No
the Maryland a or 28a-f show tifted at once.		10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Co	untry?
3a or office	5	212 S. BALLOU CT. 21231		USA	
er death with the Maryland , or items 23a or 28a-f sho r must be notified at once	lera Lera	11. Mantal Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (3. Marcied Free Forces) 14. Was Decedent of Hispanic Origin? (3. Marcied Free Forces) 15. Was Decedent of Hispanic Origin? (3. Marcied Free Forces) 16. Was Decedent of Hispanic Origin? (3. Marcied Free Forces) 17. Was Decedent of Hispanic Origin? (4. Marcied Free Forces) 18. Was Decedent of Hispanic Origin? (4. Marcied Free Forces) 19. Was Decedent of Hispanic Origin? (4. Marcied Free Forces)		- 14. Race - Ame White, etc.	rican Indian, Black,
ter dea ", or il		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify.		Specify: BI	JACK
ours aft	<u> </u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind or during most of working life. DO NOT use re		16b. Kind of Business	i/Industry
16 n 72 h nan "n ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ourou,		
5-003 led withi Hygiene.	<u> </u>	10TH MAINTENANCE 17. Father's Name (First, Middle, Last) 18.Mother's Name	ne (First, Middle, N	APARTME Maiden Surname)	NIS
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", c event, the Medical Examiner		RUSSELL L. FREEMAN, JR. MATTIE	NICHOLAS	SASHER	
tis affic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is n injury or other traumatic	ŀ	RUSSELL FREEMAN 212 S. BALLOU CT., 20a. Method of Disposition (Name of cemetery.)	BALTIMOL Date	20c. Location - City of	or Town, State
other 1	1	1 Burial 2 X Cremation 3 Removal from State crematory or other place)	106 10007	5500 O'DÓN	
Baltimore, oermit. Pages 1 ar Department of He Important: If ite Important: If ite Impury or other tr	ŀ	4 Donation 5 Other Specify: BAYVIEW CREMATORY 04 21. Signature of Funeral Service Licens 22. Name and Address of Facility WE	<u>/06/200/</u> ESLEY CHA	BALTIMORE,	MD 21224 NRL HM.
Balt permit. Depart Import injury		1/1/04/ / KAN-# 2007-09 EASTERN	AVE. B	ALTIMORE. N	4D 21231
Physician / /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death) a Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death
		Sequentially list conditions, b			
		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Consequence of):			
ted nisit	Xan	events resulting in death) Last Due to (or as a consequence of):			
60, ate be executed hysician and e burial - transit	Eg -	UNPENDED X AMENDED D 075 1/11/00 FFF			
'60, ate be physici he buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	
687 certific	Sician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic preg	nancy	Month	Day Year
Box 687 e death certificather attending ped for use as the	Pnysic	1 Yes 2 No 9 Unknown 9 Unknown			
that the death certificat red by the attending ph detached for use as the by the Dhucician/M		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to s 2 V No 3 Pr	
cords, P.C. law requires that has been signed to 2 should be deta	Completed by	Chronic Renal Disease	- 24a. Was	an 24b. Were	autopsy findings available
COrc				rmed? death?	
Division of Vital Records, P.O. lad or Attending Physician: The law requires that the start death. In Birrector: After this certificate has been signed by led in by the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted.	3 -	25. Was case referred to medical 26.Place of Death (Chec		2 N 1	Yes 2 No
f Vita Physicia or this cerral direct	ן מ	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other,4 Nur	sing Home 5	Residence 6 Oth	ner:
Ing Pi		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 ✓ Natural 5 Deading	28d. Describe	how injury occurred	
Sior Attenc r death r death by the	gat	Natural 5 Pending 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Location (Street and Number or I	Rural Route Number, City
Division of Vital Recspital or Attending Physician: The Incours after death here this certificate Infilled in by the funeral director, page		3 Suicide 6 Could not be determined (Specify)	or Town, S		,
2 >		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a cone) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To the within 2 To the complet	Medical	and manner stated. 29b. Signature and title of certifier. 29c. License number		29d. Date signed (A	
		O.C.M.E.		April 3, 2007	
	+	30. Name and address of person who completed cause of death (Item 23a)			
		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
Stat Registra	17	31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 6 2007			
DHMH 17 Rev 1/200	1	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 13,000 BW SHIRLEY ANN GRAY 200 /Medical own, or Location of Death Facility Name (If not institution, give street and number 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) If IJnde If Under 24 Hrs 9. Birthplace (State or Foreign Age (In yrs **Funeral** Months Days Min. Hours 1 ☐ M 2**∑** F Director 238-70-4265 59 JUNE 30, 1947 NC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural" or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 220 NORRIS ST 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 **X** No BLACK 1 ☐ Yes 2 🔀 No Specify: ģ 3 ☐ Widowed 4 No Divorced Completed Baltimore, Maryland 21215-0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medis Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK Be ပ FLOSSIE CARTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL L. GRAY/SON 904 W. LEXINGTON ST. - APT. #7, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5500 O DONNELL ST. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 04/21/2007 BALTIMORE, MD BAYVIEW 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Eun al Seg 2007-09 EASTERN AVE., BALTIMORE, MD that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line. , or complications that caus List only one caus n each 23a. Part1. Enter the disease shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the IF FEMALE: JSe 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate Division or Vital 2 X No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 npatient 2 ER/Outpatient 3□ DOA Certification: To this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainle as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dary 10

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William H. Gaffney Jr. 2100 PM 200 /Medical Facility Name, (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Himore Ha Osegale anklin are Under 1 Year | If Under 24 F cial Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 / 6 / 1923 Birthplace (State or Foreign Country) **Funeral** Days Hours **1** 2 □ F 83 Yrs. 213-14-2504 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Baltimore Rosedale Directo MD 10f. Zip Code 10g. Citizen of What Country? WIIIan 10e. Street and Number 21237 USA 1002 Brightstone Dr. Apt 103 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2€No Specify: white \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dentist self employed ed other event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be i Health and Mental marked William H. Gaffney Sr. Edith Reinhard ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 103 Kaye J. Gaffney/ wife 1002 Brightstone Dr. Apt. timore. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State April Evans Funeral Chapel- Bel Air 15 o Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2007 4 ☐ Donation √5 ☐ Other (Specify) Forest Hill, MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD₂₁₂₃₄ 1. Enter the disease, or one or ck, or heart failure. List only nplications that caused the death. Do not enter the one cau a on each line. Immediate Cause (Final **Physician** resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **V**No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours.
the Funeral Directory filled in br 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) Name and add 15+1

DHMH 17 Rev 1/2001

ο State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April **Physician** 1 4 Day 2007 Donald Gingher, Sr. 2:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 3 - 2 8 - 1 9 2 5 5. Social Security Number Birthplace (State or Foreign Country)
 P A 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1**™**M 2□F Yrs. 82 490-44-8097 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 2904 Dunmore Rd., Apt. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ZAYes 2 No If Yes, Give Year or Dates WWII 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event, the ponce. Medic US Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vera E. Unknown Conce Gingher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Gingher - Wife 2904 Dunmore Rd., Apt.B, Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-18-07 Bayview Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home, PA, 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** transitional Carcinoma months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was autopsy performed? certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 5 Pending investigation 1√∐Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20051926

12+1

State Registrar

Gardan 32 Registrar's Signature 31. Date filed (Month, Pay Year) APR 1 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles & Baltonone MD 6565 N.

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			State of Maryland / Department of Health and M	•	•	
			1- State Registrar Certificate of Death		g. No2 0 0 7	11979
1	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death	1	3. Time of Death
	/Media			April	12 2007	3:400
7	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	h
	Funeral		26 Bella Vita Ct. Apt. 1B Westminster 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Carroll	nplace (State or Foreign
λ.	Director		219-42-9205 1 M 2 F 63 Yrs. Months Days Hours Min.	June 20	(1943 Ma)	nplace (State or Foreign untry) ryland
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryli f sho ied at	jo	Maryland Carroll Westminster			1 ∐Yes 2√ No
	r 28a	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
	th wit 23a o 1st be	a D	26 Bella Vita Ct. Apt. 1B 21157		U.S.A.	
	er dea tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specity Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		15. Decedent's Education 16a. Decedent's Usual Occupation	1	6b. Kind of Business/	
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Š	rt tr		Kenneth Goodman, Sr husband 26 Bella Vita			
ore,	es 1 a of Hea		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 2	Oc. Location - City or	
ij	. Pages tment of tant: If its jury or o		4Donation 5只Other (Sperify) tombment Evergreen Mem. Garden	16,200 s	Finks	burg, Md.
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.C.	khardt	Funeral	Chapel P.A
		1	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	wn Rd.	Owings M	ills, Md.
	Physician	9	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final	or respiratory arre	ot,	Interval Between Onset and Death
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	be executed ician and burial-transit	хап	that initiated events resulting in death) Last c. Due to (or as a consequence of):			
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89	rtificat ng ph) as th		IF FFMALE.			
Вох	ath ce ttendii or use	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli Month	
	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Worldi	Day Year
, O.	w requires that the de been signed by the should be detached	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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000	law re	Completed		24a. Was an		topsy findings available
Œ =	The ate has page	mo.		autopsy perform 1⊟ Yes 2	ed? death?	ompletion of cause of 2□ No
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital: Hospital: Other: Other:			
Division or Vital Records,	Phys r this ral dir	P.	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho	me 5 Resider 28d. Describe hov	nce 6 Other (Spec	eify)
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 ★ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	o the vithin 2 or the o the omple	Med	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month	n. Dav. Year)
	- s + 0		Palinathy P.O. H0056488	1		2007
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	′		-3.4000- 11
	1	l l	Robin Motter, D.O. 9 Schilling Road, Hunt Valley, M	D 2103C)	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 6 2007			
	negisti	all.				

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

		1 - State Registrar			Cert	ificate of L	Death			Reg. No.	200	7 119	80
7		1. Decedent's Name (First, Middle	e, Last)									3. Time of Dea	ath
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		Suburban Hos	pital			Ве	these	da		l N	lontgom	ery	
Funeral		5. Social Security Number		ge (In yrs. last i	birthday)_	If Under 1 Year	If Under		8. Date of Bir (Month, Da	th Voor	9. Bir	thplace (State or Fo	oreign
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Ma-f s	당	Maryland Montg	gomery	R	lockvi	ille						1 ▼ Yes 2[□No
h the	Director	10e. Street and Number				10f. Zip Code			·	10g. Citiz	zen of What Co	ountry?	
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deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces		13. W	as Decedent of H Yes, specify Cuba	ispanic Or	rigin? (Sp	ecify Yes or No)- 1	14. Race - Ame		
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tal H d oth	Be	17. Father's Name (First, Middle,	•				18. Moth	er's Name	(First, Middle	, Maiden	Surname)		
Men Men arke	ဥ	Richard F. G	retsch						Jean		<u>-</u>		
2 sh and is m		19a. Informant's Name/Relations				Address (Street						•	
and ealth m 27		Carol Ann Grets	sch / Sister			e Park,	Beau						
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service	\			Name and Addressert A. Pun			al Home	/ Roclar	rillo Tr	· ·	
90 # # 9		Madettel	mount MC	01305	300	West Mont	goner	y Aver	ue, Rock	ville.	. Maryla	nd 20850-28	305
		23a. Part1. Inter the disease, or shoc or heart failure. List	complications that cause only one cause on each l	d the death. D	o not enter	r the mode of dyin	g, such as	s cardiac	or respiratory a	ırrest,		Approximate Interval Betwee	en
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/Medical		resulting in death)	a	a consequenc									
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law r as be 2 sh	ple	Obesity, Morbi	d						24a. Was			utopsy findings ava completion of caus	
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ian: rtiffica ttor, I	Be C	25. Was case referred to medica	l				26. Plac	e of Deat	(Check only				
nysic lis ce direc	To E	examiner? 1 ∐ Yes 2∭ No	Hospital: 1 📉 Inpat	ient 2 ER/	Outpatient	3□ DOA Othe	er: 4□N	ursing Ho	me 5□Res	idence 6	Other (Spe	ecify)	
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ath.	atio	2 ☐ Accident investig	gation	, ,	,,		Yes 2□]No					
Afte er de recto by th	itic	3 ☐ Suicide 6 ☐ Could of determ	ined Zoe. Flace of In	jury - At home, tc. (Specify)	farm, stree	et, factory, office			28f. Location (Street and wn, State)	d Number or R	ural Route Number	r,
talon safte al Di	Certification:		3,						-1.9 07 10				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical	ng Physician: To the besi Examiner: On the basis	t of my knowled of examination	ige, death and/or inve	occurred at the tir	ne, date a pinion, de	ind place, eath occur	and due to the	cause(s)	and manner a	s stated. e to the cause(s)	
the I	Medical	one)	and manner s	tated.		29c. Licenso							
S IN C S	<	29b. Signature and title of certifle	(11.11								e signed (Mon		
, - Y			J. Wilk	5			63195)		Apr	il 8, 2	2007	
		30. Name and address of person					เรียกก	D a =1		M	.10-1 0	0.850	
<i>)</i>		Steven D. Wilk 31. Date filed (Month, Day, Year)	32. Req	trar's Signature		enter Dr	_ve,	ROCK	ville,	mary	rand Z	0000	
Sta Registi		APR :	1 6 2007	Since a A	1 1	bastes							
		mill.	L U LOUI	Chara V	- 17								

			1 - State Amend #7, perFH, go	State of Maryland / Dep 66 , 4/16/07 TT $C6$	ertificate of Death	Reg. N				
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death			
	Physici /Medic		LUSE		HURST	April 10	2007 11:15 A M			
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			future Car	e-tryington	Baltimo	re	NA			
	Funeral		5. Social Security Number 6. Sex		y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Cpugtry)			
	Director	-	217-28	M 2LVF 3 89 Yrs.		Oct 0,19.	1 Georgia			
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location		10d. Inside Çity Limits			
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	with	<u>=</u>	2025 W	les stage	7-1225	3	IICA			
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(0	ifter of their	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.			
ğ	al', c	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: DOR			
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, If a Meulcal Examination at	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a. Dec	edent's Usual Occupation we kind of work done during most of wor	tking 16b. I	(ind of Business/Industry			
7	ithin nan	du	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	Λ	m./			
	led w lygiel her ti		5/2a	NA	Domestic	1 /	une marco			
anc	be fi	Be	17. Father's Name (First, Middle, Last)	(18. Wothers Nan	ne (First, Middle, Maide.	n Surname) ,			
ž	should ind Men a marke umatic	^c	reorge E	a British	Rose	ann	TAILLS			
Maryland	d 2 sl th an 7 ia r traur		19a. Informant's Nam Pelationship (Type	st-daughter 950	iling Address (Street and Number or Ru	2. 1	or I for it G2220			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exandrational traumatic event.		20a. Method of Disposition	20b. Place of Disc	position (Name of	Date 20c. L	ocation - City or Town, State			
Jor	Pages nent of I unt: If its ury or o		1 ☑ Burial 2 ☐ Cramation 3 ☐ Re	emoval from State cemetery, cr	ematory or other place)	(-n) 0				
Baltimore,	artme artme ortan injura		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fine eral Service License	Loudo	22. Name and Address of Facility	270 Fred H	literiare, mer			
Ba	permit. Departr Imports any inji		Jours M		Parer P. march F	,	me Baeta ud, 2,229			
			23a. Part Epter the direase, or complic	cations that caused the death. Do not en		or respiratory arrest,	Approximate Interval Between			
	-		Immediate Cause (Final	e cause on each line.	and Auto	0.	Interval Between Onset and Death			
	/Medical		disease condition resulting in death)	Due to (or as a consequence of):	may mile	y wis	case			
П	Examiner				(7.0)	<i>c</i>				
		Jer	Sequentially list conditions, cause. Enter Underlying	Due to (or as a consequence of):						
	ate be executed obly sician and the burial-transit	Examiner	that initiated events							
O	e exe ian a urial-l	Ë	resulting in death) Last	Due to (or as a consequence of):						
68760,	cate be ex physician the buria	dical	d							
9	ific g p	=								
0	X is the solutions of pregnancy									
Ď	ath cert	ian/Medi	23b. Was decedent pregnant		☐ Ectopic pregnancy		23d. Date of delivery Month Day Year			
O. Box	he death cert the attending	ysician/Medi		1 Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)					
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Vital Records, P.O.	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 25 Was case referred to medical examiner? 1 Yes 2 No 27 Manner of Deeth 1 Matural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 20c Accident 1 Certifier 20c Medical Examin	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown Itributing to death but not resulting in the Augustian 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time Injury 28b. Place of Injury - At home, farm, shuilding, etc. (Specify) stician: To the best of my knowledge, deater: On the basis of examination and/or and manner stated.	underlying cause given in Part I. 26. Place of Dea ent 3 DOA Other: 4 Nursing H of 28c. Injury at Work? M 1 Yes 2 No street, factory, office ath occurred at the time, date and place investigation, in my opinion, death occur	24a. Was an autopsy performed? 1 Yes 2 X Autopsy performed? 1 Yes 2 X Autopsy performed? 28d. Describe how injute 28d. Describe how injute 28d. Describe how injute 28d. Location (Street a City or Town, State 29d. Describe at the time, date and 29d. Describe 29d. Descr	Month Day Year use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) In occurred and Number or Rural Route Number, and of place, and due to the cause(s) atte signed (Month, Day, Year)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 9, **Physician** 2007 2:45 Charles Edmund Hergenroeder рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 9206 Bretton Reef Rd. If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2 □ F Director 69 09/26/1937 Maryland 215-34-8774 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show be notified at 1 ☐ Yes 2 X No **Funeral Director** Parkville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 23a 9206 Bretton Reef Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items 11. Marital Status Black, White, etc. or other traumatic event, the Medical Examiner 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Baker/Owner Bakerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Dorothy C. Sporrer John E. Hergenroeder ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. 9206 Bretton Reef Rd. Parkville, MD 21234 Etta Hergenroeder 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial 04/13/2007 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. out of Alexandrias 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Brain Tumor Malignant C
Due to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending newsizion and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	_		
4a.	Was	an	
	autop		
_	perfo	rmed	?_

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

1□ Yes 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25.	Was case examiner? 1 ☐ Yes	4	to	medical
27.	Manner of	Death		

5 Pending investigation 2 Accident

6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. injury at Work?

2∏No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

23e. Did tobacco use contribute to the cause of death?

4 Homicide 29a. Certifier

one)

3 ☐ Suicide

(Check only

1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License number BL1509528

29d. Date signed (Month, Day, Year) 04/11/2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Laterra

The John Hopkins Hosp. 600 N. Wolfest.

21287

State Registrar

Completed by

Be (

Certification: To

Medical

31. Date filed (Month, Day, Year) APR 16 2007



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apri Day Vear 13:10PM AMES 2007 MAVILAND 12 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOPKINS BAYVIEW ALTIMONE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**∑**M 2□F 69 Oct. 4, 1937 Maryland 216-32-1735 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Maryland Edgemere 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21219 7220 Waldman Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Steel 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James A. Haviland Margaret Little 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgemere, Maryland 21219 Candide Haviland (Wife) 7220 Waldman Avenue 20a. Method of Disposition 1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 □Removal from State 4 Donation 5 Cther (Specify) 4/16/2007 Hilltop Service Corp. Towson, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Espiration Due to (or as a consequence of) Moine hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 110 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation

Physician /Medical Examiner death certificate be executed

Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show idical Examiner must be notified at

the Medical

permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M

Director

Funeral

δ

Completed

Be

2

with the Maryland

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

physician and sthe burial-tran as attending p ned by the a signed I has ÷ this

Physician/Medical 2 Completed Be ပ္ Certification:

Division or Vital Records. Attending Physician: To the Hospital or Attending Prnysi within 24 hours after death. To the Funeral Director: After this i completely filled in by the funeral dir

> State Registrar

Medical

6 ☐ Could not be

determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

1 ☐ Yes 2 ☐ No

31. Date filed (Month, Day, Year)

29b. Signature and tibe of certifier

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 10, 2007 **Medical Examiner** 0905 hrs John Edward Herbold, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Days Hours Foreign Country) Months Director 214-76-0294 49 06/12/1957 MD 1 M Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 10a State 1 Yes 2 No 28a-f show s 23a or 28a-f shov e notified at once. MD n/a Baltimore City Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 1411 Locust Street 21226 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 8lack, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married American Yes 3 Widowed If Yes, Give Year 1 Yes 2 No specify: 4 Divorced Indian Specify. "natural" þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of 8usiness/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than c event, the Medical Transportation Engineer Trucking 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John Edward Herbold Molly Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margauritte Herbold/Wife 1411 Locust Street, Baltimore, MD 21226 of Health of If item 2 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, Burial 2 Cremation 3 Removal from State 04/18/07 Welch Family Cem Cherokee, NC Donation 5 Other Specify 22. Name and Address of Facility G. J. Gonce Funeral Home, PA 21. Signat of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line 8etween Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). certificate be executed and g by the attending physician ached for use as the burial -X UNPENDED 4/18/07_TI 7. perME. 2866. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy Physician/M 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Year Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has . death? page ✓ Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital director Be Other₄ Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 After this 1 V Yes 2 No ဥ 28a. Date of Injury (Month, Day Year 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred 27 Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending death . the Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined the Funeral 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c License number 29b. Signature and title of certific 29d. Date signed (Month, Dav. Year) O.C.M.E April 11, 2007 30. Name and "ddress of person who con letted cause of death (Item 23a) Susan Hogan MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Register's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 31 AM 433 L B ORE ARRIEL 10 2007 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SACTIMORE DIPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Birthplace (State or Foreign Country) 5. Social Security Numb 7. Age (In yrs. last birthday) **Funeral** Months 55.37.3 1 M 2□F 7 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "neture!, or itema 23a or 28a-f show the Medical Exeminer must be notified at 1 ¥ Yes 2 □ No Baltimore by Funeral Director WD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1244 Court 15A Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Heelth and Mental Hygies Important: If fram 27 is marked other th eny finjury or other treumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Harriel orraine Dubose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Father 20b. Place of Disposition (Name of cametery, crematory or other place) Baltimere John Harriel mo alayy 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount 04.17.2007 Baltimere mo 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

23a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

23a. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

23a. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

23a. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

23a. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NON-Physician KIN /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physicien and 1 be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 Tes 2 🗆 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the dates(s) and infamor as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 301 OSTA 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 April **Physician** 14, Rose Marie Iampieri 3:50 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year 03/04/1917 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 ☐ M 2 🖫 F Director 213-52-7394 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified. Maryland Howard Ellicott City Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8979 Furrow Avenue 21042 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>Ş</u> Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic s 1 and 2 should be filed w if Health and Mental Hygier item 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John M. Weber, Sr. Mary Jankowiak ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. James F. Iampieri / Son 8979 Furrow Avenue Ellicott City, Maryland 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cemetery 04/18/2007 West Friendship, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes, 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rears Due to (or as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To after death.

I Director: After this d in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

di

(Check only one)

ttelen

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 1 6 2007

1/14/07

Tampieri, Rose

DHMH 17 Rev 1/2001

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29d. Date signed (Month, Day, Year)

MD 21204

Baltonorp

and manner stated.

an

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M Gardon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Y**e**ar 238p M NFS FRANCES 2007 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death PARKINGTON HVENUE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Days 1 □ M 2 🔀 F Months Hours SOUTH CAROLINA AUG. 05,193 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MARULAND 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) THGRADE 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) WILLIAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTELL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State -16-07 WOODLAWN, MARYLAND 4 Denation 5 ☐ Other (Specify) of Funeral Pervice Licensee 21. Sign 22. Name and Address of Facility 2140 N. Fulton Avenue 110 21217 Joseph H. Brown, Jr. Funeral Home Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown inificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy perform 1∐ Yes 2 **2** No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year)

Box 68760, P.O. I Division or Vital Records,

be executed and as the burial-tran attending physician signed by the a been si should b page 2 this certificate Physician: director, funeral After or Attending death. within 24 hours after death To the Funeral Director; completely filled in by the the Hospital

sician/Medical Be 2 Certification:

Medical

Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed by

Be ဥ

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

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1 Natural 2 Accident 3 ☐ Suicide

29a. Certifier

(Check only one)

5 ☐ Pending investigation 6 Could not be 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

-405

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 12,2001 Maril

28f. Location (Street and Number or Rural Route Number, City or Town, State)

325 HOSFICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE, SNITE ZCS DK. OCHANEY mo 2106

State Registrar 31. Date filed (Month, Day, Year) APR 6 32 Registrar's Signature

			For	State of Maryland / Department of Health and M	Mental Hygien	1e2007 11005
_			1 - State Registrar	Certificate of Death	Reg. N	40.CUU/ 11300
п	Physici	an	Decedent's Name (First, Middle, Last)	T11 1-1	2. Date of Death Month	3. Time of Death
	/Media		Josephine	Ellen Johnson	4 0	7 2007 3:00 PM
سنر	Examir	er	4a. Facility Name (If not institution, give	~ [Ma.a.la 2 11 /	4	c. County of Death
	.		5. Social Security Number S. Sec	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	a Bistolan (Ctuber Ferri
	Funeral Director		DOX-47_021/10	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	D		Usuel Residence of Decedent		11 19-1	434 Virginia
	how	_	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	Ba-f e	cto	MD	Dathmore		1 XYes 2 □ No
	with th	Dire	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	72 hours after death with the Maryland naturel', or Items 23a or 28a-1 ehow Jical Examinar must be notified at	by Funeral Director	496 Mittai	1Klintown Ka. 21216		USA
	ter d	-un	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Diversity No.	pecify Yes or No- Pican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	urs af	by F	3 Widowed 4 Divorced	1		Specify: Rlack
Õ	72 ho	Completed	15. Decedent's Edu		16b.	Kind of Business/Industry
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	filed with Hygiene. other ther	Con		Detary Supervis	or	tospital
and	be fill H d otl	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maide	n Sumame)
3	should be nd Mental marked c	٩	TODEYY DUO	ger Viola	Stitt	1
Maryland	d 2 7 le		19a. Informant's Name/Relationship	be Print)	ral Route Number, City	or Town, State, Zip Code)
	1 an Heal Heal ther		20a. Method of Disposition	20b. Place of Disposition (Name of	Date 20c	Location - City or Town, State
ğ			1 Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State	11 00 2	silions a Mi
Baltimore,			21. Signature of Funeral Service License	22. Name and Address of Facility	14-0.1 T	CIALLIANOR MD
B	permit. Departr Imports eny Inj		Murdon C. I	1,0000 8728 liberty R	2 Rand	allation IN OIR
			23a. Part1. Enter the disease, or compli	Tations that caused the death. Do not enter the mode of dying, such as cardiacle cause on each line.	or respiratory arrest,	Approximate
	Physician		Immediate Cause (Final disease or condition	STROKE		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):		7 0495
	Examiner		Sequentially list conditions, b	HYPERTENSION		
	D #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		
LE.	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
60,	icate be execu physicien and s the burial-trar		and the second second	Due to (or as a consequence of):		
68760,	ficate be executed physicien and s the burial-transit	edicai	d			
_		/We	IF FEMALE:	3c. If yes, outcome of pregnancy		004 0-1-4 4-1
Вох	death certi e attending id for use a	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
P.0.	w requires thet the di been signed by the should be detached	Physician/M	9 Unknown	9□ Unknown		
	law requires thet the as been signed by the 2 should be detache	by P	Part II. Other significent conditions con	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ğ	en sig	ed			1 ☐ Yes 2	2 No 3 Probably 4 □Unknown
e C C	as 2	ple			24a. Was an	24b. Were autopsy findings available
œ	The ate h page	Completed			autopsy performed? 1 ☐ Yes 2 ☑ N	
/ita	or Attending Physician: The iffer death. Director: After this certificate ha in by the funeral director, page	Be	25. Was case referred to medical examiner?		h (Check only one)	0 1000
5	hysic this c	욘	1 ☐ Yes 21X No	ospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Specify)
ב	After Junera	ion:	27. Manner of Death 1 SaNatural 5 ☐ Pending	(Month, Day Year) Injury Work?	28d. Describe how inju	ury occurred
S	death ctor: / the f	Icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	204 1	
Division of Vital Records,	l or A after Dire	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Stat	and Number or Rural Route Number, te)
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 17 Certifying Phys	 cian: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause/o	s) and manner as stated
	n 24 I	Medical	(Check only 2 Medical Examin one)	er: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	ed at the time, date an	d place, and due to the cause(s)
	To t To tl	Σ	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
,			Marce XI	P13154	41	9/2007
	5			poloted source of death (Item 02a) (Turn Brink)	1	
	~		MARC SIMARL	1 22 S. GREENE STRUEL KOLLING	IE MID :	21201
				# Registrar's Signature	4/10	
	Stat Registra		31. Date filed (Month, Day, Year) APR 1 6 2007	22 5 GREENE STRUET BATTIMON	4,710	

		ļ	State of Maryland /	-			d Mental Hyg	giene	* 11000
			1 - State Registrar	Cei	rtificate of	Death		Reg. No.	/ 1989
ę.	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Y	3. Time of Death
1	/Medic	cal	Matilda Kostkowski 4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of D	April	8, 2007 4c. County of	
	Examir	ier	St. Elizabeth Nursing Home			more (n/a	
ja.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24 l	Hrs. 8. Date of Birth		Birthplace (State or Foreign Country)
	Director		216-32-8915 1 1 M 2 M F 89	Yrs.	Months Days	Hours	Hrs. 8. Date of Birtl (Month, Day 04/28,	/1917	MD
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Lo	cation				10d. Inside City Limits
	anyla shov	2							1 ☐ Yes 2 No
	the M	Director	MD Anne Arundel Pas	ade	na 10f. Zip Code			10g. Citizen of Wh	at Country?
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Ö	241 Ninth Street		211	22		U.S.A	
	ms 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No-	14. Race -	American Indian,
ယ္	after or Iter		Armed Forces? 1 Marver Married 2 Married 1 Yes 2 Marver Married 2 Marver Married 1 Yes 2 Marver		If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Pi Specify:	uerto Hican, etc.)		White, etc.
21215-0036	rai", c	l by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		TEL TES ZIE NO	эреспу.		Specify:	White
5-0	72 h 'natu dical	Completed	15. Decedent's Education 16 (Specify only highest grade completed)	a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of	working	16b. Kind of Busi	ness/Industry
121	within ene. than '	Id III	Elementary/Secondary (0-12) College (1-4or 5+)			a)		Own H	0.00
	illed v Hygie ther t		8 17. Father's Name (First, Middle, Last)	HOIII	emaker	18. Mother's	Name (First, Middle,		
Maryland	2 should be filed w n and Mental Hygie is marked other t raumatic event, th	o Be	Felix Kostkowski			Till	lie Matu	zewski	
Z	2 should be and Meni is marked raumatic e	T ₀		b. Mailir	ng Address (Street		r Rural Route Numbe		tate, Zip Code)
	1 and 2 Health a em 27 is		Sandra Brandt / Niece 2	41	Ninth S	treet	Pasade	na, MD	21122
altimore,	of Heal		Zod. McGrod of Disposition	of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Location - C	ity or Town, State
E	Pages nent of I ant: If Ite		1 Maurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holy		oss Cem				ore, MD
alti	permit. Pag Department Important: I any injury o		21. Signature of Soneral Sorvice Licensee	- 1					al Home, PA
8	83588		Mul low						MD 21122
e.	- 3		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ent					Approximate Interval Between Onset and Death
W	Physician		Immediate Cause (Final disease or condition resulting in death)) V	PDE	all	1011	ure	Szeurs
1	/Medical Examiner		Due to to les a consequence	e of):	1110	dill	fail.		Sugar
0	officer. The	7	Sequentially list conditions, if any leading to immediate. Due to (or as a consequence)	e of):	100	0000			Jens.
	ited nsit	nin.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	,					
Ć,	execunate and and all-tra	Examiner	resulting in death) Last C Due to (or as a consequence	e of):	<u></u>				
8760,	ysicia e bur	dical	d						
9	rtifical ng phy as th	ledi	IS SEMALE.						
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal dea	th 3[∃Ectopic pregnanc	y		23d. Date Mont	
	e dea the att	sici	in the past 12 months? 1 Yes 2 No 9 Unknown	5	Other (specify)			Wolfe	n Day Tour
P.0	that the de led by the a detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting	in the u	nderlving øause giv	ven in/Part I.	23e, Did to	obacco use contrib	oute to the cause of death?
ds,	ires tha signed d be del	by	Uringry tract	,2	APC.	Bon	101	٠.	B Probably 4 ☐ Unknown
Vital Records,	w requir	Completed by		/			24a. Was	an 24h W	ere autopsy findings available
Rec	he law	шb					— autor	nsy pri rmed2 de	ior to completion of cause of ath?
a	sician: The certificate har rector, page		25. Was case referred to medical			26 Place of	1 Yes Death (Check only o		□Yes 2□No
5	ysicia is certi directo	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C	Outpatie	nt 3 DOA Oth	2011	ng Home 5 ☐ Resid		(Specify)
0	ding Phys h. After this funeral di	7: To	27. Manner of Death 28a. Date of Injury 28b	. Time o				now injury occurred	
ion	ath. It: After Ie funer	atio	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation (Month, Day Year)	injury		Yes 2 No			
Division	er der recto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, sti	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	or Rural Route Number,
Ö	ital o	Cer							
	Hosp 4 hou Fune ely fill		29a. Certifier (Check only (C	ge, deat and/or ir	h occurred at the ti vestigation, in my	ime, date and p opinion, death	place, and due to the occurred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, gompletely illied in by the funeral director,	Medical	one) and manner stated. 29b. Signature and title of certifier	. 17	29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	N N N) / / / / M	4	0 -	279		Sil-	9.2007
4	7		30. Name, and address of person who completed cause of death (Item 23a	ı) (Type.		- / /	1	up!	1,000/
- 1	-	1	I make the second of the secon			0 10	A	11 4 // //	

State Registrar 7813 Maryknoll Avenue

1 Never Married 2 Married

17. Father's Name (First, Middle, Last)

Frank Zukauskas

Funeral

þ

Completed

Be

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Examiner

by Physician/Medical

Completed

Be

Medical Certification: To

"natural", or Item: ledical Examiner n

traumatic event, the Medical

and Mental Hygiene.

Health i

permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other to

Physician

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.O. Box 68760

Division or Vital Records,

/Medical Examiner

Baltimore, Maryland 21215-0036

2.5	sda		
	10f. Zip Code	10g. Citizen of What Coul	ntry?
	20817-2953	United Stat	es

Rockville

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Days

1 ☐ Yes 2 No

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

20b. Place of Disposition (Name of cemetery, crematory or other place)

Elizabeth Janusauskas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Reg. No.

12,

Day

1915

2007

Montgomery

14. Race - American Indian,

White

Black, White, etc

Specify:

Own Home

20c. Location - City or Town, State

4c. County of Death

2. Date of Death

8. Date of Birth (Month, Day, Year)

1,

Month

April

3. Time of Death

12:10

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Pennsylvania

 A^{M}

19a. Informant's Name/Relationship (Type. Print) Margaret E. Lewis/Daughter

20386 19431 Transhire Road, Montgomery Village, MD

18. Mother's Name (First, Middle, Maiden Surname)

20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Gate of Heaven Cemetery Silver Spring, Maryland 2007 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc.
300 W. Montgomery Avenue, Rockville, Maryland 20850

April 17,

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

only one	dementia
	Due to (or as a consequence of):
b	
	Due to (or as a consequence of):

M01173

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ears

	Due to (or as a consequence of)
į	d
	23c. If yes, outcome pf pregnancy

4☐ Pregnant at time of death

	23d. Date of delivery
Ectopic pregnancy Other (specify)	Month D

IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No

9 Unknown

9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 □

23e. Did tobacco use contribute to the cause of death
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkno

Day

Year

1 🗌 Yes	2 No	3 ☐ Prol	bably	4 Unkno
24a. Was an autopsy performed 1 Yes 2 ☑	?_^	Were auto prior to co death? 1 \(\sum Yes		dings availa on of cause

28f. Location (Street and Number or Rural Route Number, City or Town, State)

25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient

			26. Pla	ice of Death (Check only one)	
2 🗆	ER/Outpatient	3 🗆 DOA	Other: 4	Nursing Home	e 5 Residence	6 □Other (Specif
(ear)	28b. Time of	28c	Injury at Work?	28	d. Describe how in	jury occurred

27. Manner of Death 5 Pending investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be

28a. Date of Injury (Month, Day Y 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c.	Injury at Work?		28d. Describe how injury occurred	
	1 🗌 Yes	2 🗌 No		

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D.20148

29b. Signature and title of Aifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) even 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Olinsk.

Russell Ave. Gathersburg

M

State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician ADELYA** KHODORKOVSKAYA 12:30 PM 11 12007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | LEVINDALE 8. Date of Birth Month Day Year) 02/26/1933 Birthplace (State or Foreign Country)
 DILCC TA Social Security Number 7. Age (In yrs. last birthday) **Funeral** 215-39-7159 1 □ M 2 🕱 F 74 RUSSIA Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rthen "naturel", or iteme 23a or 28a-f shov tre Medical Examiner must be notified at 1√ Yes 2 No MD N/A BALTIMORE Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6101 PARK HEIGHTS AVENUE, #T-221215 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5 Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) REKKEL BRASLAVSKAY TALBA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6101 PARK HEIGHTS AVENUE #T-2-BALTIMORE, MD 21215 LAZAR KHODORKOVSKIY/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Important; if Iter
eny injury or oth 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 04/13/2007 REISTERSTOWN, MD 4 Donation 5 Other (Specify)

21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DISTASE CORONARY BRTERY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as ettending properties of the second se IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ EREBRO VASCULAR DICIDENT 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy performed? Yes 200 No certificate ha irector, page 2 RENAL CHRONIC 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a
To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10063327 4/11 Sturm H- Wordentimon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVEGERE AVE, BALTIMORE, MID 2. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

APR 1 6 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 13, 2007 Hannelore Linden April 10:30a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Health and Rehab Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/26/1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 214-62-3523 1□M 2XF Germany Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Health and Mental Hygiene. and the filem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Maryland Anne Arundel Baltimore 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4032 Belle Grove Road Germany 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 specify: White 1 ☐ Yes 2 No Specify: Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4032 Belle Grove Road Baltimore Maryland 21225 Irene Linden/ Daughter Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4/16/07 Hill Top Serv. Corp. Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, MD 21214 5305 Harford Road Leonard J. Ruck, Inc. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician or as a consequence of): yomary /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes after death. Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hry hway Sw Olin Burnie 1911 21061 208 Cram Registrar

P.O.

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State of Maryland / Department of Health and	Mental Hygiene

		- For State egistrar		Certif	ficate of	Death			Reg. No).		_
Physician		. Decedent's Name (First, Mid-	dle,Last)					Date of D Month	eath Day	Yea		Time of Death
dical Examine		Robert Ea						April 12	, 2007			1521 hrs
	4	fa. Facility Name (if not institut		umber)	4	b. City, Town, or I Rosedale	Location of Dea	ath		c. County of Baltimore		tv
	۹.	Franklin Square Hos	6. Sex	7. Age (In yrs. last	hirthday)	If Under 1 Year	If Under 24H	trs 8 Date of				place (State or
Funeral Director		5. Social Security Number 218 - 32 - 4925	1 M 2 F	7. Age (III yis: last	Yrs.	Months Days		Nov6			Foreign	
šı	_	Usual Residence of Decedent 10a, State 10b, County	,	Inc. City. To	own or Location	on					T1	Od Inside City Limits
ow any	Γ		timore	1	ггу Н							1 Yes 2 X No
Maryland 28a-f show d at once.	<u>.</u>	Oe. Street and Number				10f. Zip Code			10g. Ci	tizen of Wh	at Countr	y?
th the Maryland 23a or 28a-f sho notified at once.	<u> </u>	4917 Tartan	Hill Ro	ad		21128				U.S	Δ	
vith th		11. Marital Status		cedent Ever in U.S.	13. Was	Decedent of His	panic Origin? (Specify Yes or	No-	14. Race	- America	n Indian, Black,
or death with or or items 23	1	1 Never Married 2 I	Married Armed F	orces?	If Ye	s, specify Cuban,	Mexican, Pue	rto Rican, etc.)		White	, etc.	
ifter d		3 X Widowed 4 D	ivorced If Yes, Give Ye or Dates:		1	Yes 2 X No	specify:			Specify:	Whi	te
nours and a sami		15. Decedent's Education (Sp	ecify only highest gra			's Usual Occupati st of working life.			16b.	Kind of Bus	siness/Inc	dustry
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Europeal Director	i de	Elementary/Secondary (0-12	College (1-4 or 5+)	March	nouse M	[anaco	r	1.7	actai	an F	lectric
OOS withing giene.		1 Z L II 17. Father's Name (First, Middl	e. Last)		wale			ne (First, Middl				rectife
	١٥	Jeremiah Je		ch, Sr.			Mary '	T. Bur	not	es		
D 2121 should be fi and Mental 7 is marked natic event,	٦ و	19a. Informant's Name/Relation	nship (Type, Print)			Address (Street	t and Number o	or Rural Route N	Number, (City or Town		
2 0 0 3		Mary M. Col	acioppo/									
re, N s I and f Health If item		20a. Method of Disposition 1 X Burial 2 Cremation	on 3 Removal f	rom State cre	matory or oth			Date		. Location -		
도 스 의 를 늘		4 Donation 5 Other		St.S								Maryland
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tri	ľ	21. Signature of Funeral Service	ce Licensee									Home, PA
_ ====	1	23a Part I. Enter the dilease,	or complications that	caused the death. D	o not enter th	e mode of dving.	such as cardia	c or respiratory	arrest, si	more s	art MC	. 21222 Approximate Interval
Physician /Medical	ľ	failure. List only one caus	se on each line.									Between Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)		sclerotic ca a consequence cf):	ardiovas	cular dise	ase			_		<u> </u>
	1	Sequentially list conditions,	b									
		if any, leading to immediate cause. Enter Underlying Caus		a consequence of):								
ted nisit		(Disease or injury that initiated events resulting in death) Las	Due to (or or	a consequence of):								
and and - transit			d			_						
ala e	/Medical	X UNPENDED	X AMENDED	a,27,perME,	G866, 4	/30/07 TT				_		
Box 68760, e death certificate be the attending physic of for use as the buri	Me	IF FEMALE:	23c. If yes	, outcome of pregna	ncy	al death 3 [Ectonic pred	nancy	2	3d. Date of Month	delivery Da	y Year
Sox 68 leath certificate attending for use as the second of the second o	sıcıan	past 12 months?	L	nant at time of deat	_ =	ardeath 3 [ner (Specify)		griancy		Month	54	,
Box he death the atte	Š			nown								
res that the signed by t	by Phy	Part II. Other significant cond	ditions contributing	to death but not resi	ulting in the u	nderlying cause g	iven in Part I.					ne cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safer death al Director: After this certificate has been signed by lled in by the funeral director, page 2 should be detach	g			 		<u></u>	 -					opsy findings available
cords, law requir has been s	Completed							au	ras an utopsy erformed	F	orior to co death?	mpletion of cause of
Reco	Ē								es 2		✓ Yes	2 No
Vital Rec ysician: The l	8	25. Was case referred to medi examiner?					of Death (Che				Jau	
'Nit	0	1 ✓ Yes 2 No	Hospital: 1		R/Outpatient 28b. Time of I		ry at Work?	rsing Home 5		njury occurr	Other:	
ding Pl		27. Manner of Death 1 X Natural 5 Pe	28a. Dat (Mon	e of Injury th, Day,Year)	ob. Time of ii		Yes 2 No	200. Desail	DC 110W 11	njany occum	ou .	
Sion Attend death death sector:	ğ		vestigation	ice of Injury - At hom	ne farm stree			28f. Locatio	on (Street	and Numb	er or Rura	al Route Number, City
Divis	Certification	de	termined (Specify		10, 14111, 51191		3,		n, State)			
lospit 4 hour nners		29a. Certifier 1 Certifying	Physician: To the be		, death occur	red at the time, da	ate and place, a	and due to the o	cause(s)	and manner	as stated	d.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death within 24 hours after death completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical E	xaminer:On the basis	s of examination and	l/or investigat	ion, in my opinion	, death occurre	ed at the time, d	ate and p	olace, and o	lue to the	cause(s)
To Son	ĕ -	29b. Signature and title of cert		/)	29c. Licens	e number		290	d. Date sign	ed (Mont	th, Day, Year)
		(ara	0 4	Lall	eli	O.C.	M.E.		Ap	oril 13, 20	007	
	I	30. Name and address of pers							'			
	_		Assistant Medica		11 Penn S	Street, Baltim	ore, MD 21	201				

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 13, 2007 Year 12:01 P. M **Physician** Emma A. Lewis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Franklin Square Hospital 8. Date of Birth (Month Day, July 15, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 86 Yrs. If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Days Hours Min Marviland 1 □ M 2 XXF 214-14-7756 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State "naturai", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐Yes 2 No Bel Air Harford Mary land Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 1338 Agora Place Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White filed within 72 hours after 2 XNo 1 ☐ Yes 2 🛣 No Specify: 2 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within ; h and Mentai Hygiene. 7 is marked other than "r Johns Hopkins Hospital Elementary/Secondary (0-12) College (1-4or 5+) Admissions Coordinator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marken any injury or exercise. Elizabeth Lawrence Earl Dyson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1338 Agora Place Bel Air Maryland 21014 Patricia Kerr /Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐ Removal from State Gardens of Faith Baltimore Maryland 4-16-07 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21. Signature of Funeral Service License 23a, Part1. Enter the disease, or complications that caused the rath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 20 No 3 Probably 4 ☐Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rector, page 2 performe 2 No 2□ No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3□ DOA 1 ☐ Yes 2 No 1 | Inpatient ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Manner of Death Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

the Hospitai or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, nerai Director: / within 24 hours at

To the Funeral D

completely filled i

Baltimore, Maryland 21215-0036

2

State

110 Mammor 31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29b. Signature and

29a. Certifier

Medical

determined

Marie 32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

timon MOZIZZZ

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 5:58 f M /Medical Apri 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bayview Medical Center Bathmer Johns Hockins 5. Social Security Number N/A **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 🎗 💢 F Director 101 220-44-8161 Usual Residence of Decedent 5, 1906 Feb. Pennsylvania the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d Inside City Limits must be notified at Director 1 ☐ Yes X☐ No Maryland Baltimore or 28a-f Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other than "natural", or items 23a or 1 any Injury or other traumatte event, the Medical Examiner must be n. 13 Admiral Boulevard Funeral 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ William H. Fulmer Willhelmina Kauber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Lessig (Son) 13 Admiral Boulevard Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Moreland Mem. Pk. 4/10/2007 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe **Physician** Tevere hypercapneic respiratory acidosis disease or condition resulting in death) day /Medical Examiner Decompen Sated Due to (or as a consequence of): weeks Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Preumonia physician and the burial-trans Due to (or as a consequence of): Fibrillation Atrial Physician/Medical use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy ō Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□ Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No X 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an 1 To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division or Vital Records, P.O. Box 68760,

Registrar

0

31. Date filed (Month, Day, Year) APR 1 6

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Mignel

Medical

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Munoz

4940 Eastern Avenue Baltimore, MD 21224 2. Registrar's Signature

MEDICAL DOCTOR

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** AM 11:30 Theresa 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
If Under 1 Year | If Under 24 Hrs JOHNS HOPKINS BAYVIEW MEDICAL CENTER Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Numbe **Funeral** Months Davs Min. Hours 1 □ M 2√2 F Director 63 March 15, 1944 Maryland 212-44-9129 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or Items 23a or 28a-f show dies! Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 108 Ventnor Terrace 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes ≱☐ No Specify Specify: ģ 3 □ Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own_Home or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Charles E. Tracey ပ Margaret A. Kessler nt of Health and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Walter S. McClusky (Husband) 108 Ventnor Terrace Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important; If any Injury or 4□Donation 5x1Other (Specify) Entombment Holly Hill Mem. Gdns. 4/16/2007 Middle River, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 11. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Immediate Cause (Final disease or condition resulting in death) Physician Arrythmice /Medical Due to or as a consequence of): Examiner End Stage Chronic Obstructive Pulmonary Disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-trar and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the as IF FEMALE for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **p** 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificate has autopsy performed 2 No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, Hospital or Attending 124 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in by th within 24 hou To the Fune completely fi

> State Registrar

(Check only one)

rystal

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Eastern

29c. License number

29d. Date signed (Month, Day, Year)

Avenue Baltimore, MD 21224

2007

and manner stated.

4940

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 13, 2007 Nancy J. McNealy April 10:39 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 820 Reserve Champion Drive Rockville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 25, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 🂢 F Yrs. **Director** 21**7-**34**-**0098 70 1937 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28s-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiena.
ant: It item 27 ie marked other than "natural; or iteme 23a or 28a-f ehor ury or other traumatic event, the Medical Examinar trinut be notified at 1 X Yes 2 ☐ No Directo Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 United States 820 Reserve Champion Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Real Estate Elementary/Secondary (0-12) College (1-4or 5+) Investment Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Goldie Ayers George William Kilpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger L. McNealy, Sr./Husband 820 Reserve Champion Drive, Rockville, MD 20850 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) April 15, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Depertment or Important: It eny Injury or once. Montgamery Crematorium 4 ☐ Donation 5 ☐ Other (Specify) 2007 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, Inc. Milliam M01173 300 W. Montgomery Avenue, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Brain Tumor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physicien end hed for use as the burial-transit Attending Physicien: The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown B cell lymphoma Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 2 No certificate 1 Yes Be 25. Was case referred to medical examiner? ___ 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Injury 1 Natural
2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No deeth. I Director: A investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Momicide after To the Hospital within 24 hours a To the Funerel [1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

atucia

31. Date filed (Month, Day, Year)

Patricia Tomsko Nay,

10ms1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

D51916

11119 Rockville Pike, G-100, Rockville, MD

April 13, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2:18 A M April 2007 Robert Joseph Moore 12, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Nursing and Rehab Montgomery **Burtonsville** 8. Date of Birth (Month, Day, Year)
Sept. 14, 1922 Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min 1 M 2 □ F 84 230-09-3041 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location items 23a or 28a-f show ner must be notified at 1 NYes 2 No Directo Rockville Montgomery Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 United States 202 Cedar Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 口 Yes 2科 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Examiner Yes 2 1 Never Married 2 Married 1 □ Yes 2 No White Baltimore, Maryland 21215-0036 "natural", or Specify Specify: If Yes, Givo Year or Dates: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Printing the Lithographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Rita Elizabeth Middlekamp John Tilford Moore ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S 20872 10904 Middleboro Drive, Damascus, Maryland permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trat once. Mary H. Griffin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 16, 1 Burial 2 □ Cremation 3 □ Removal from State Rockville Cemetery 4 Donation 5 Dother (Specify) 2007 Rockville, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis Syndrome /Medical Due to (or as a consequence of) **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Comfort Care, Advanced Dementia, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hypertension 24a. Was an autopsy performed?

1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 13, 2007 D53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20902 9801 Georgia Avenue, Suite 117, Silver Spring, MD Shyamsundar Rajan, M.D. 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For State	State of Marylar			and Men	tal Hygien	ne	
			Registrar 1. Decedent's Name (First, Middle,	(act)	Centitica	ate of Death	2 [Reg. No. 1	lo.	3. Time of Death
	Physici		A B	lellons-Nito	ih ooa				ay Year	10:14PM
	/Medio Examin		Marquerite 4a. Facility Name (If not institution,			ity, Town, or Location of	of Death	2111 10	tc. County of Death	10
			1040 East 3	3rd Street Apt	220	Balt im	ore			
	Funeral		5. Social Security Number	5. Sex 7. Age (In yrs. 1 ☐ M 2 💢 F	Month	der 1 Year If Under:	Min. (Date of Birth Month, Day, Yea	r) Cou	place (State or Foreign ntry)
	Director		257-30-4078 Usual Residence of Decedent	X	Yrs.		n	narch 9,	1926 (7)	4
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Location					10d. Inside City Limits
	Mary Fig.	to	MD		Baltin	Merre				1 Yas 2 □ No
	th the)ire	10e. Street and Number			Zip Code		10g. (Citizen of What Cou	ntry?
	ath wi	Funeral Director	1040 East. 33	"Street Apt	220	2121	8		USA	
	er de	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was De If Yes, s	cedent of Hispanic Original Control of the Control of C	gin? (Specify n, Puerto Rica	Yes or No- in, etc.)	14. Race - Ameri Black, White	
36	urs aft	5	1 ☐ Never Married 2 ☐ Marrie 3 🕱 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:			Specify:	ach
21215-0036	i within 72 hours after death with the Maryland liene. r than "natural", or iteme 23a or 28a-f show the Madical Examinar roual be mullied at	Completed	15. Decedent's	Education	16a. Decedent's U	Isual Occupation work done during mos	t of working	16b.	Kind of Business/Ir	
21	□ 3	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired)			1	
			17. Father's Name (First, Middle, L	act)	-	buse wife	r's Name (Fi	rst, Middle, Maid	OML Sumame)	
anc	S a b s	Be C	_	131/		Day	Bai	14.	o oao,	
Maryland	should and Menis markets	ဥ	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailing Addr	ess (Street and Number	or or Rural Ro	oute Wumber, Cit,	y or Town, State, Zi	p Code)
Ž	s 1 and 2 should f Heelth and Men item 27 is marke other trsumatic		Della Thomas	2/ Daughter	1040 E	05t 33cd	Stree	+ Ba	etimore 1	no 21218
ore,	of He of He roth		20a. Method of Disposition 1 Daurial 2 Cremation		Place of Disposition (incemetery, crematory)	Name of or other place)	Date	20c.	Location - City or T	own, State
Ĕ	nit. Pages artment of l ortant: If its injury or or		4 ☐ Donation 5 ☐ Other (Sp.	ecify)	Irbutus	C	11.16.		cultumer.	mo
Baltimore	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service L	censee	22. Name	and Address of Facility	n ()	_		none 3/1/18
	40244		23a. Part1. Enter the disease, or o	omplications that caused the dea	th. Do not enter the n	node of dving, such as			usteur 1	Approximate
Ų	Dhusisian		shock, or heart failure. List o Immediate Cause (Final	nly one cause on each line.	0	-114				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec		HY				
	Examiner		Sequentially list conditions,	CONGESTIV	E HEAL	2T FAIL	uR	E		
	D H	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					
72	xecute and II-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	quence of):					
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	ifficate g phy as the	edic		U						
Вох	eath certifi attending I for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet.		c pregnancy			23d. Date of deliv	,
	e deat he att	Physician/Me	in the past 12 months?	4□Pregnant at time of o					Month	Day Year
P.0	The iaw requires that the death certifi te hes been signed by the attending tage 2 should be detached for use as		9 ☐ Unknown Part II. Other significant condition	s contributing to death but not re	sulting in the underlyin	ng cause given in Part I	- 3	23e. Did tobaco	o use contribute to	the cause of death?
ds,	signed I	d by	Takin other organical			, , , , , , , , , , , , , , , , , , ,		1 🗆 Yes	2 No 3 Pro	
cor	w requir been si should	ete					- 10.	24a. Was an	24b. Were aut	opsy findings available
Vital Records,	: The law cate hes I	Completed				-		autopsy performed 1 Yes 2 🛣	? death?	ompletion of cause of 2 No
ital		BeC	25. Was case referred to medical			26. Place	of Death (C	heck only one)		
of V	d is	5	examiner? 1 Yes 2 No		+		rsing Home	5 Residence		ıfy)
o uc	ding Ph h. After th funeral	inol in	27. Manner of Death 1 Natural 5 Pending		28b. Time of Injury M	28c. Injury at Work?		. Describe how in	njury occurred	
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<u>S</u>	affor affor	Certification;	4 Homicide determine	building, etc. (Spec		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, St	(ate)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer		29a. Certifier Scornitying	Physician: To the best of my kn examiner: On the basis of examin	owladge daith occur	rad at the time, date ar	id plans, and	dua to the cause	s(s) and manner as	stated to the cause(s)
	ths H hin 24 ths F nplete	Medical	one)	and manner stated.		29c. License number			Date signed (Month	
	T vit	-	29b. Signature and title of certifier	A. Nalin		D34184	1.	290.	117 1 A n	, Jay, 1541)
			20 Name and address of parson	tho completed cause of death (Ite	m 23a) /Type Print)		_	7	113/04	_
	4		RAYMOND A.	NZE 7801	YORK RI	7 H100, 7	owso	in m	02120	4
		ate	31. Date filed (Month Pay, Year)	007 32. Registrar's Sign	ature					
	Regist	rar		The state of the s						

Registrar

07-02851 Ε

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ethel Owens		epartment of Health and Mental Certificate of Death		No. 200	7 1200
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last) Ethel Owens		2. Date of Death Month April 14, 20		3. Time of Death 0939 hrs
The state of the s	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of E		4c. County of Death Baltimore Cour	ntv
Funeral	5 Social Security Number 16 Sex 17 Age (In vrs. last hirthday) I If Under 1 Year I if Under 24Hrs. 18 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or				
Director	265 34 5677 1 M 2 X F 90	Yrs. Months Days Hours	May 31,	1916 Foreign	South ""'Carolina
any	Usual Residence of Decedent 10a. State 10b. County 10c	City, Town or Location			10d. Inside City Limits
er death with the Marylan s, or items 23a or 28a-f s r must be notified at on Funeral Directo	Maryland Baltimore Essex 1 Yes 2 X No				
	10e. Street and Number 1 Brett Court Apt. 224	10f. Zip Code 21221	10	g. Citizen of What Count USA	ry?
	11. Marital Status 1 Never Maried 2 Married Armed Forces?	r in U.S. 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Po		14. Race - Americ White, etc.	an Indian, Black,
	1 Yes 2 X 3 X Widowed 4 Divorced If Yes, Give Year or Dates:	No 1 Yes 2 No specify:		specify: Black	
hours aft fragural' fragine ted by	45. Decedently Education (Considerable blands grands grands and 16h		16b. Kind of Business/Ir	6b. Kind of Business/Industry	
5-0036 led within 72 hour Hygiene. International Example Completed	3	Homemaker	ker Own Home		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene Important: If item 27 is marked other til injury or other traumatic event, the Med					
212 hould be and Ment is mark utic ever	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
and 2 sho lealth and tem 27 is traumat	Carol Owens (Daughter) 20a. Method of Disposition	20b. Place of Disposition (Name of cemetery,	Date Mai	20c. Location - City or	
Baltimore, semit. Pages 1 ar Department of He Important: If ite	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or other place) Bayview Crematory	1/16/2007	Baltimore,	Maryland
Balti Departu Imports injury o	21 Signature of Funeral Service Licensee			ki Funeral I	
Physician	John W. Burkeusko 1407 Old Eastern Avenue Essex, Maryland 21221 3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and				
/Medical maminer	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Death Due to (or as a consequence of):				
	Sequentially list conditions, b				
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.				
outed nd ransit					
50, te be executed ysician and burial - transit	UNPENDED AMENDED				
5876 ertificate ling phy e as the l	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year				
box 6876 the death certificat the attending phy ched for use as the Physician/M	1 Yes 2 V No 9 Unknown 4 Pregnant at time of g Unknown 5 Other (Specify)				
, P.O. Box 6876 res that the death certificat signed by the attending phe be detached for use as the death of the bed by Physician/M	Part II. Other significant conditions contributing to death but Chronic obstructive pulmonary disease, diab			2 No 3 Prob	
cords, law requires has been sig 2 should be npleted	24a. Was an autopsy prior to completion of cause of				
Records, P.(The law requires tha ficate has been signed , page 2 should be det			perform	med? death?	
sion of Vital Attending Physician death. death. y the funeral director cation: To Be	25. Was case referred to medical examiner? Hospital: Inpatient	26.Place of Death (C 2 ER/Outpatient 3 DOA Other,		Residence 6 🗸 Other	Scene
	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month Day Year) (Month Day Year) (Month Day Year)				
	Natural 5 Pending Accident Investigation				
	Suicide 6 Could not be determined Specify Specify Solution Solutio				
Divis To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)				
To To To Med	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon			nth, Day, Year)	
	(alive)	O.C.M.E.		April 15, 2007	
2	30. Name and address of person who completed cause of death Zabiullah Ali, M.D. Assistant Medical Exam		D 21201		
State Registrar					
DHMF 1/2001 ORIGINAL					

DHMH 17 Rev 1/2001 OCME 2006